

Evaluation of WHO transformation

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ACRONYMS

ADG	Assistant Director-General
AFRO	WHO Regional Office for Africa
AMRO/PAHO	WHO Regional Office for the Americas/Pan American Health Organization
CSS	Department of Country Strategy and Support
DAF	Director of Administration and Finance
DE	DeftEdge Corporation
DPM	Director of Programme Management
DG	Director-General
EB	Executive Board
EMRO	WHO Regional Office for the Eastern Mediterranean
ERG	Evaluation reference group
ERP	Enterprise Resource Planning system
EURO	WHO Regional Office for Europe
FGD	Focus group discussion
GPG	Global Policy Group
GPHG	Global public health good
GPW 12	Twelfth General Programme of Work 2014-2019
GPW 13	Thirteenth General Programme of Work 2019-2023
HQ	WHO headquarters
HRGE	Human rights, gender and equity
IEOAC	Independent Expert Oversight Advisory Committee (WHO)
ILO	International Labour Organization
IOAC	Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme
KII	Key informant interview
MoU	Memorandum of Understanding
NPO	National Professional Officer
NSA	Non-State actor
PB	Programme Budget
R&D	Research and development
RD	WHO Regional Director
RO	WHO Regional Office
STDA	Short-term developmental assignment
SDG	Sustainable Development Goal
SDG3 GAP	Global Action Plan for Healthy Lives and Well-being for All
SEARO	WHO Regional Office for South-East Asia
UHC	Universal health coverage
UN	United Nations
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNGA	United Nations General Assembly
UNHCR	Office of the United Nations High Commissioner for Refugees (the UN Refugee Agency)
UNICEF	United Nations Children's Fund
UNSDCF	UN Sustainable Development Cooperation Framework
WCO	WHO Country Office
WHA	World Health Assembly
WHE	WHO Health Emergencies Programme
WPRO	WHO Regional Office for the Western Pacific
WR	WHO Representative

EXECUTIVE SUMMARY

BACKGROUND

WHO transformation

The WHO transformation was launched in July 2017 with the establishment of the Working Group on Change Initiatives and was broadly communicated with the release of the WHO Transformation Plan & Architecture in February 2018. It was conceived as an organizational change initiative aimed at better equipping WHO to achieve the ambitious goals set forth in its Thirteenth General Programme of Work, 2019–2023 (GPW 13) – that is, greater impact at country level in pursuit of the triple billion goals and the health-related Sustainable Development Goals (SDGs) – by optimizing its use of resources, streamlining processes and ensuring it is fit for purpose in a rapidly changing world. Within this context, the ultimate aim of WHO transformation has been to “make WHO a modern, seamless, impact-focused Organization to better help Member States achieve the health-related Sustainable Development Goals in the context of United Nations reform”.

WHO transformation has taken place within a wider context of ongoing change and reform, both within WHO and within the wider United Nations system. Within WHO, it is the latest in a series of reform efforts that the Organization has undertaken over the years. As such, it represents a continuation of these initiatives in that it addresses long-standing issues that WHO, like most organizations, faces on an ongoing basis (for example, endeavouring to become ever more efficient and streamlined), while also redoubling its efforts to tackle other challenges that it had failed to adequately overcome in prior reform efforts (for example, cultivating a more agile work force), as well as targeting new areas for change that have emerged as a result of developments in WHO’s operating environment in recent years (for example, the need to strengthen partnership with non-traditional donors and non-State actors).

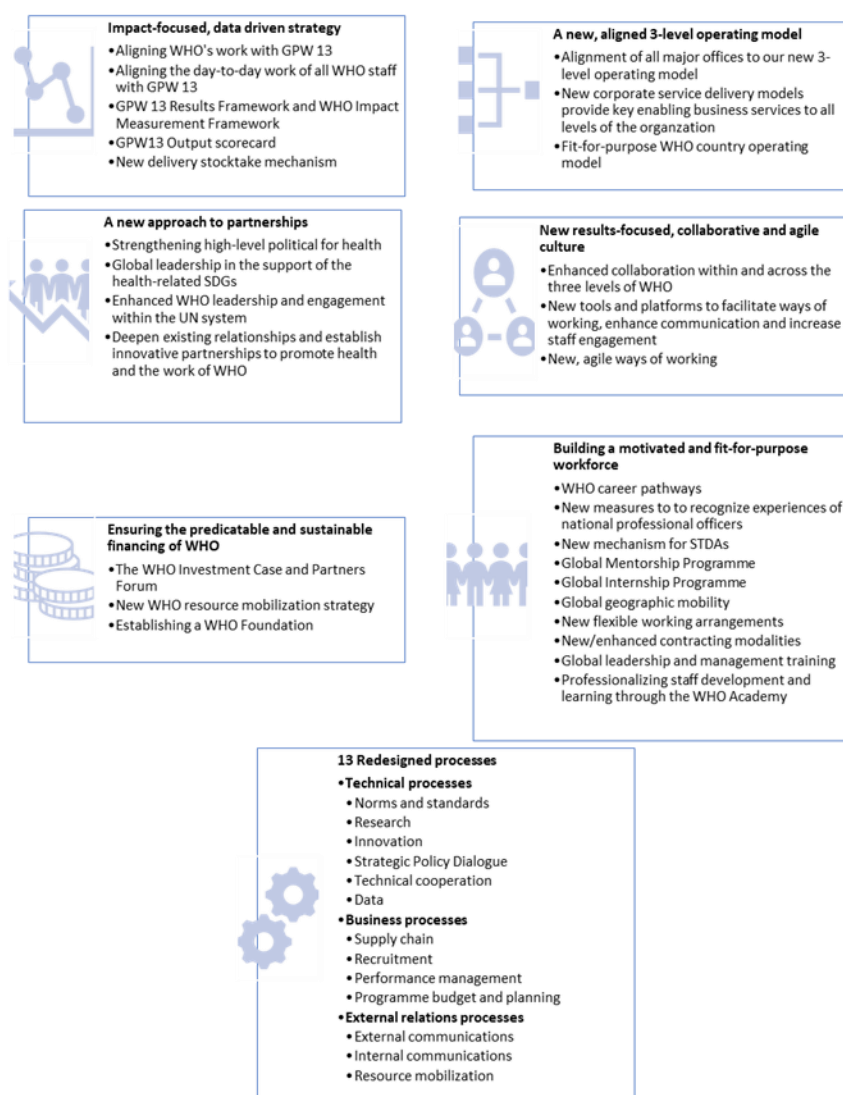
Within the United Nations system, WHO transformation contributes to WHO’s response to the broader policy currents of United Nations development system reform and United Nations reform. Under this movement, the system has been reorienting itself toward the strengthening of its collective support to countries – as well as collective accountability for this support – as a means of helping to achieve the ambitious goals of the 2030 Agenda for Sustainable Development, and with it the SDGs.

Accordingly, what distinguishes WHO transformation is less its broad objectives or even its specific initiatives than its clear grounding in the Organization’s strategic direction as it has shifted its orientation toward the 2030 Agenda and the SDGs. The GPW 13 explains the “what” (achieving impact at country level, on the health-related SDGs broadly and the triple billion goals specifically) and broadly lays the groundwork for “how” it aims to achieve this. WHO transformation has aimed to translate this “how” into a specific set of change management initiatives. It thus represents the instrumental vehicle for achieving the broad goals outlined in the GPW 13, both within the Organization and as it works with others towards the shared goal of the 2030 Agenda and the SDGs.

Key elements of WHO transformation

Though encapsulated under a single, Organization-wide initiative, in reality WHO transformation has not been a uniform undertaking. First, in programmatic terms it represents a range of distinct but interrelated set of changes, organized along seven work streams (Figure 1 provides an overview of the workstreams and their corresponding initiatives). Together, these workstreams represent both the “hard wiring” aspects of organizational change (for example, the structural reorganization to better position WHO for increased impact at country level; the operational changes required to streamline the processes that enhance timeliness, effectiveness and efficiency in its work; and so on) and the “soft wiring” aspects (for example, improvements to organizational culture that help attract and retain the most qualified staff for the task at hand; opportunities for and supports to career development; greater staff mobility; and so on).

Fig. 1: Seven workstreams of WHO transformation and their corresponding initiatives



Second, in view of the uniquely decentralized nature of the Organization, there has been considerable variation in both the paths and the timelines pursued between headquarters and regional offices and among the regions themselves: whereas the entire Organization has worked hand in hand toward the broad goals enshrined in WHO transformation, some regional offices (for example, the Regional Office for Africa) began pursuing transformation initiatives prior to the launch of the Organization-wide endeavour and all of the regions have been adapting the overarching areas of transformation in ways that are optimally tailored to the specificities of their respective regions.

Finally, WHO transformation has not been static in its evolution or its roll-out. Rather, it has evolved over time by adding or refining initiatives in line with emerging needs; its initiatives have evolved on different timelines in light of inherent differences in complexity, time to payoff or deliberate phasing in the broader sequence of changes; and these patterns have varied across the regions, owing to the aforementioned differences in approach. Therefore, while WHO transformation does represent a process of cohesive organizational change at the highest level, its roll-out has been a rather more complex array of change activities that vary by timeline and location.

Roles, responsibilities and timeline

WHO transformation was spearheaded by WHO's Director-General. Leadership in setting the course for transformation has been vested in a Global Policy Group (GPG), currently consisting of the Director-General, the Deputy Director-General and the Regional Directors. Day-to-day management of the overall transformation process has been carried out by the Transformation Team, under the guidance of the GPG, established in the Office of the Director-General for this purpose. From the outset of the transformation design process, the Transformation Team brought together working groups at all levels of the Organization that included staff of each regional office. The Transformation Team initially managed all transformation processes as well, including the set-up and management or co-management of some of the redesigns indicated in Figure 1 before handing these over to designated business owners within the Organization. The localized design and roll-out of transformation at regional level has been carried out by regional Transformation teams under the stewardship of the regional directors. To support specific aspects of the process, external expertise has been engaged from a range of management consulting firms.

WHO transformation has been undertaken in four phases. The first phase, undertaken in the second half of 2017, consisted of consultations and analytics and informed the GPG deliberations and the Director-General's decision-making, culminating in the WHO Transformation Plan & Architecture. The second phase, spanning from February 2018 to March 2019, was focused on the Transformation's design and thus led to the development of the GPW 13, the redesign of 13 key WHO processes and a new WHO-wide operating model. The third phase, from March 2019 to December 2019, focused on alignment and initiated changes to organizational structure and methods of work and the development of the WHO Values Charter. The fourth phase on implementation started in January 2020. This phase is the final and longest phase and remains ongoing.

THE EVALUATION OF WHO TRANSFORMATION

The overarching objective of the evaluation was to assess the progress of WHO transformation at all levels of the Organization from July 2017 to date and the status of implementation of the WHO Transformation Plan & Architecture. More specifically, the evaluation was tasked with:

- documenting key achievements, good practices, challenges, gaps and areas for improvement in the implementation of WHO transformation thus far;
- assessing whether change management issues and barriers to implementation have been appropriately considered and addressed; and
- making recommendations, as appropriate, on the way forward to enable the full and consistent implementation of WHO transformation.

In light of the ongoing implementation of transformation, this evaluation was a formative exercise – that is, forward-looking in its orientation, with a view to providing key stakeholders (that is, the Secretariat, Member States and others) with an independent, objective and impartial assessment of progress to date and, in so doing, identifying any necessary course corrections to help inform implementation of transformation moving forward.

Approach, scope and methods

The evaluation was included in the 2020–2021 biennial evaluation workplan, which was approved by the Executive Board at its 146th session. The terms of reference were finalized in consultation with the Independent Expert Oversight Advisory Committee (IEOAC) at its 30th meeting, in April 2020.

The IEOAC was engaged and was regularly apprised of the evaluation’s progress throughout the process. An evaluation reference group consisting of colleagues from all three levels of the Organization and all seven major offices was established to inform and support the evaluation in an advisory capacity.

The evaluation began with an inception phase, resulting in a report detailing the approach to be followed for implementing the terms of reference – beginning with a matrix that translated the overarching evaluation objectives articulated in the terms of reference into specific evaluation questions to be answered in the exercise. The two main, overarching questions were as follows:

1. To what extent has WHO transformation, in its overarching design and in its specific elements, been relevant to meeting the organizational reform and change management objective of being fit for purpose, as envisaged for the Organization at this juncture in its evolution?
2. How effective has WHO transformation been thus far in delivering on its targeted actions according to plan and in orienting WHO towards the achievement of its intended outcome-level and impact-level results? What have been the key results achieved, best practices, challenges, gaps and areas for improvement? How likely is transformation to contribute to the achievement of the goals outlined in GPW 13 and the SDGs?

Each of these evaluation questions was further operationalized by a series of sub-questions. The evaluation also included a range of cross-cutting questions pertinent to the evaluation objectives (for example, facilitating the factors and barriers to implementation affecting WHO transformation’s implementation to date; how adeptly WHO has leveraged its human, financial, technical and technological resources to maximize the Transformation’s success in the most efficient, internally consistent and coherent, whole-of-organization manner; and gender, equity and human rights considerations).

As with all WHO evaluations, the overall process and methodological approach followed the principles set forth in the WHO evaluation practice handbook and the United Nations Evaluation Group Norms and

Standards for Evaluation and Ethical Guidelines for Evaluation. The evaluation applied a mixed-methods, inclusive and participatory approach, combining several sources of qualitative and quantitative evidence, including:

1. **An extensive in-depth desk review of key documents.**
2. **Semi-structured key informant individual and group interviews with 121 stakeholders,** including IEOAC and Independent Oversight and Advisory Committee members and staff members across the three levels of the Organization. In addition, focus group discussions were conducted internally, including with the staff associations at headquarters and in the regions, the general service staff network (“G-Force”) at headquarters and in 10 country offices, and externally with Member States in three focus groups in which 46 Member States were represented. Owing to COVID-19 pandemic constraints, all interviews were conducted remotely. Thus, in total, over 200 stakeholders contributed to the key informant interviews and focus group discussions.
3. **Structured questionnaires administered to two stakeholder groups: Member States and heads of WHO offices in countries, territories and areas.** For Member States, the questionnaire was distributed in the six official languages of the Organization through an official list of email addresses provided by the Governing Bodies’ department; heads of WHO offices in countries, territories and areas were also informed to encourage participation. A total of 23 Member States and 14 heads of WHO countries offices provided feedback to the questionnaires. Member States and heads of WHO country offices were also invited to request a one-on-one interview, should they so desire, and one Member State and two heads of WHO country office availed themselves of this option.
4. **An online staff survey,** including both closed and open-ended questions, which was sent to all staff in English, French and Spanish. The response rate was 14% (1287 staff members).
5. **Archival data collected from various organizations and units,** including information on human resources, finances and business processes over time.
6. **Direct observation (remotely) of key meetings and events pertaining to WHO transformation** that occurred during the data-collection phase, including the WHO Town Hall on Transformation (November 2020); an all-staff “open-house” on flexible working arrangements (December 2020); and a joint Rotary International/WHO virtual event on the theme “Together for mothers’ and children’s health” (February 2021).

The ongoing COVID-19 pandemic necessitated that all data be gathered remotely, which to some extent limited the richness of the data collected compared to in-person interactions and field observations. It also affected the availability of some key informants to participate in interviews and respond to the survey and questionnaires. Despite these limitations, the evaluation was able to gather robust data from all stakeholder groups and the level of response to the staff survey and questionnaires was taken into account when triangulating the results of the questionnaires with data obtained from other sources.

KEY FINDINGS

WHO transformation: design and process

As noted above, WHO transformation was initiated with a specific goal in mind: to equip WHO to achieve greater impact at country level in pursuit of the triple billion goals and the health-related SDGs, as envisaged in the GPW 13. It has also been conducted against the backdrop of wider reform efforts, both within WHO and the wider United Nations system. Accordingly, the evaluation aimed to assess whether WHO transformation, in its overarching design and in its specific elements, has been relevant and fit for purpose in meeting the specific organizational change management needs at this juncture in WHO's evolution.

The evaluation also assessed the process through which WHO arrived at WHO transformation design – that is, its approach to ensuring that this design was as well informed as possible by the most crucial sources of information and knowledge with respect to organizational needs and the expertise on and evidence base for the changes being considered, so that it would be as fit for purpose as possible. This assessment of the process was also important for engaging with key stakeholders – staff, Member States and partners – as a means of fostering buy-in to, support for and ownership of the Transformation so that it would ultimately be as successful as possible.

Overall, it is recognized that WHO transformation design is an ambitious, complex change management endeavour that addresses many areas requiring organizational change that will be crucial for enhancing the Organization's potential impact at country level. Moreover, a desk review of key documents makes it clear that the process that WHO followed contributed to the comprehensiveness of the design. This process was extensive and multifaceted, relying on a methodical review of prior reform efforts both globally and at regional levels: what these initiatives had and had not accomplished; the lessons they had generated; and where they had left off. The process also relied on extensive consultations with staff at all levels of the Organization and in all major WHO offices, an area that prior reform initiatives had failed to adequately embrace. It furthermore benefited from a cadre of external expertise in the form of various management consulting firms in order to ensure that WHO transformation and its individual workstreams were optimally informed by state-of-the-art knowledge in the field of change management. Finally, the management of the process has been adaptive, with WHO fine-tuning its approaches and adding workstreams as emerging needs were identified. What resulted was a suite of organizational changes that address both the "hard wiring" aspects of organizational change (for example, structural, process and policy refinements) and the "soft wiring" aspects (for example, cultural change), which are summarized in Figure 1. If these continue to be implemented well, WHO transformation could help reorient the Organization for enhanced impact at country level.

Within this broad positive assessment, however, two significant gaps – one in the design and another in the process underpinning the design and its ongoing implementation – could hinder WHO transformation's success if not addressed. **First, while the design is appropriately multifaceted in its breadth and organizational reach, it is not clear precisely how comprehensive it is in addressing all critical areas requiring change or how its individual initiatives work together in a coherent and complementary manner to truly transform the Organization, because the design was not informed by an overarching theory of change or logic model.** An inferred theory of change was retroactively developed by the evaluation team at the outset of the evaluation, with active engagement by the evaluation reference group, for the purpose of understanding the initiative so as to evaluate it effectively;

however, this externally developed framework to aid the evaluation is not a substitute for an internally developed management tool to aid the management of this ambitious, complex and high-visibility process in a strategically sound manner. Such an internally-developed instrument would serve as a clear road map to concretely articulate what the desired end state of being transformed “looks like” and precisely how the elements of transformation will work together, both individually and in complement to each other, towards this desired end state. In so doing, it would also assist those most directly engaged in and responsible for the Transformation with implementing important aspects of the change management process, including the phasing and prioritization of activities; the management of resources, process efficiency and cost-effectiveness; and risk management. Importantly, it would also serve as a vehicle for transparent communications with key stakeholders, including staff and Member States, to ensure a clear shared understanding of the road map beyond the “what” aspects of the Transformation (for example, what the objectives are and what activities WHO is undertaking toward these ends) to include also the “how” and “why” (for example, how multiple activities might mutually reinforce each other towards a single shared objective, how a single activity might be pursued to influence multiple objectives, how to avoid operating at cross purposes, why certain activities have been pursued over others towards a desired end state, and so on).

The lack of such consistent and clear communications, specifically as it relates to Member States, constitutes the second significant gap identified in the evaluation. There is strong evidence that staff were actively engaged in the process – in consultations, as change supporters and at the highest level on the GPG – and WHO staff participating in the staff survey reported a reasonably high degree of understanding of and support for WHO transformation’s overarching objectives and what is being undertaken to achieve them. By contrast, Member States contributing to the evaluation generally express a lack of familiarity with key aspects of the initiative, coupled with dissatisfaction at having been insufficiently engaged during the design phase or informed throughout implementation. Fundamental issues – such as what activities of the Secretariat are and are not considered to be directly related to transformation; what the end state of being transformed will look like; how and when they will know the Secretariat has been transformed; and where the Organization is in achieving these outcome-level objectives – all constitute important information and knowledge gaps expressed by numerous Member States.

The shortcomings in engagement with Member States to date are likely linked to a lesson garnered in previous reform efforts, whereby these efforts were noted to have been Member State-driven and top-down in approach. However, the lack of adequate engagement of Member States prevents them from adequately exercising their role and responsibilities. For some Member States, it has also resulted in missed opportunities to contribute to key change initiatives and instead might have led to perceptions that the Secretariat was not communicating as transparently as it should. Coupled with the lack of a theory of change or logic model that would form the basis for such interactions, the lack of active engagement reported by numerous Member States poses a risk to the ultimate success of WHO transformation if not remedied.

Progress to date

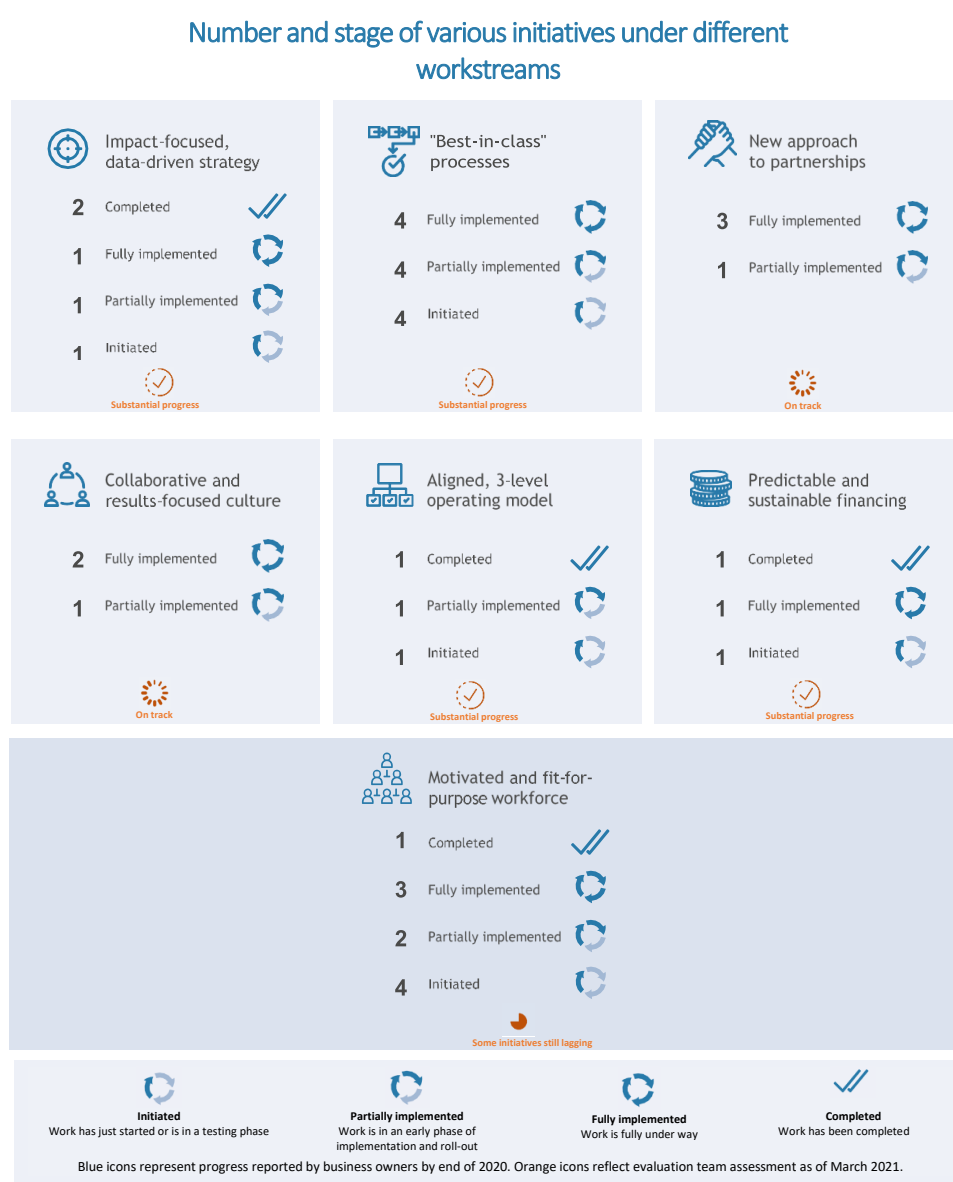
Taking the WHO transformation design and implementation plan as its point of departure, the evaluation sought to ascertain the extent to which the activities planned under WHO transformation have thus been implemented as intended (notwithstanding the aforementioned lack of a theory of change) and, to the extent that they have, what if any tangible effects these have had on the functioning of the Organization.

Importantly, the evaluation also sought to identify any evidence of transformation’s effects to date on the ultimate objective of helping achieve greater impact at country level.

Implementation progress

There is evidence that significant progress has been made in implementing WHO transformation as a whole, with substantial progress having been made in four out of the seven workstreams and two additional workstreams being on track for being mostly or fully implemented within the next few months. In only one workstream, “Motivated and fit-for-purpose workforce,” were some initiatives found to be lagging. Figure 2 summarizes the implementation status of the 40 planned activities of the workstreams to date.

Fig. 2: Number and stage of various initiatives under different workstreams



It is important to underscore that while progress has been substantial, the roll-out of the Transformation is taking longer than envisioned in the 2018 Transformation Plan & Architecture document, in which it was suggested that changes would be consolidated by mid-2019. Those activities focused on external partnerships and building a results-focused strategy are the closest to being considered fully implemented, while several business processes and human resource initiatives have lagged but progress is expected in these areas in 2021. Less progress has been made in those activities focused on fostering a motivated and fit-for-purpose workforce. However, given the uniquely decentralized structure and characteristics of WHO, the scope of the transformation agenda, the interdependencies of many of its initiatives – and the COVID-19 pandemic response, during which time gains have continued to be made within the seven workstreams despite this significant disruption – progress is nonetheless noteworthy. More staff responding to the survey agree that WHO is on track in delivering the transformation agenda than those who do not.

With respect to stakeholder sentiment about the initiative’s purpose, very few activities were identified as not being useful; where concerns were raised by interviewees, these were mainly with regard to the new headquarters structure, which was clearly challenging on a personal and professional level for some of those most directly affected by it. Somewhat more critical feedback was shared on the sheer number of actions being undertaken in parallel and the impact those had on existing workplans and the onset of “reform fatigue” (not least of all for staff in smaller operational units and in country offices whose work WHO transformation has been seeking to help rather than hinder). The slow pace of quick wins intended to foster early ownership of transformation was another shortcoming frequently raised: although all but one of these quick wins was reported as being complete in December 2018, there was mixed evidence that this was the case.

Effects of implemented activities on the functioning of the Organization

As Figure 2 indicates, progress in implementing WHO transformation has been significant, but it is still incomplete. As a result, it is premature to provide a definitive or thorough assessment of the end effects that these activities have had on the work of the Organization. At the same time, the evaluation did aim to gather the available evidence on any tangible improvements in the functioning of the Organization that have resulted from key changes completed to date, particularly in light of the recognition that, as described above, some activities might entail a shorter time horizon for observing desired changes than others. Within this context, there have been some tangible though limited improvements evidenced in the “hard-wiring” aspects of organizational change (that is, structures, processes and policies) and in the “soft-wiring” aspects (that is, more collaborative and results-oriented organizational culture). At the same time, there are areas in which targeted improvements have not yet materialized.

With respect to structures, processes and policies, there is widespread recognition by staff and Member States alike that the new operating model pursued by WHO under its transformation, whereby it has reoriented itself around achieving impact at country level to address the triple billion goals, has had concrete positive effects on the work of the Organization. These include an organizational structure that is now clearly aligned to the GPW 13; strengthened strategic planning and programme budget processes that are all aligned to the GPW 13; a cascading of the overarching organizational goals into the workplans of individual operating units and individual performance objectives; a heightened focus on results by way of strengthened monitoring, evaluation and knowledge management systems (embodied in such concrete actions as the GPW 13 Output Scorecard, the GPW 13 Results Framework and WHO Impact Measurement Framework, and the WHO Academy); more women in senior leadership positions; improved career progression opportunities for national professional staff; a deeper appreciation for the role of evidence

in the work of the Organization (exemplified in the creation of the Science Division and the role of the Chief Scientist); and importantly, a trend toward increased resources in the WHO regional offices and a more creative approach to resource mobilization more generally (which has been aided by the additional funding received for the COVID-19 pandemic response and the subsequent establishment of the WHO Foundation).

Small but positive and significant indications of progress have also been noted in the areas of WHO's organizational culture that were targeted by transformation despite the lower level of implementation progress in this workstream. A range of initiatives have been launched in this regard – for example, the WHO Values Charter, the Change Supporters Network, the open-door policy, the World's Healthiest Organization, #ProudToBeWHO and the Global Task Force on Flexible Working Arrangements – with the aim of transforming WHO into a modern, results-oriented, agile and collaborative organization that can deliver against the commitments enshrined in the GPW 13. The need for such changes within WHO has been widely and openly acknowledged for some time. At the same time, achieving significant and long-lasting changes in organizational culture are often much more difficult to achieve than structural or process changes. The small but positive changes detected at this stage of transformation are therefore particularly noteworthy. In particular, staff members' belief that they are heard and valued and that staff ideas and expertise were being respected increased, arguably because the baseline sentiment on these was quite low.

Beyond these perceived shifts toward a stronger and clearer results orientation and towards a more inclusive environment for staff, few tangible results have been observed to date at the country level. For example, less progress has been made in resourcing WHO country offices with the staff they need to achieve impact, either through the deployment or creation of posts at this level, the rotation of staff from other corners of the Organization to the field or a combination of both of these measures. A small number of WHO representatives surveyed do express appreciation for the support provided by WHO regional offices and headquarters to augment their staff, but this support appears to be an exception to a broader phenomenon in which little progress has been realized to date. First, since 2016 more new posts have been created at headquarters than in regional or country offices. Second, staff mobility, a key outcome targeted by the Transformation as an essential step in helping WHO country offices achieve greater impact (while also circulating knowledge between headquarters and the field, forging a common identity as "One WHO" and enhancing staff members' professional development), has not yet increased as planned. Third, in country and regional interviews, staff indicate that the Transformation has not yet been able to reverse the top-heavy nature of staffing tables. Finally, interviews with WHO representatives and others indicate that, in order to be maximally effective in achieving greater impact at country level, they need to be invested in through a leadership development process that is commensurate with the increasing demands now being placed on them.

Another important area targeted by WHO transformation that has not yet witnessed significant positive change is related to the goal of reducing the time spent on administrative processes. The digitization of some of these processes, such as approval mechanisms and communications, do seem to be streamlining some aspects of the Organization's day-to-day operations. However, staff members interviewed and surveyed suggest that the centralization of key processes has increased the amount of time spent on some administrative processes – for example, in the time it takes to recruit candidates urgently during global and country-specific emergencies and in recruitment of staff in WHO country offices, where the need for WHO is most acute. These issues are being addressed during this latter stage of the transformation agenda's implementation, so it is not yet possible to assess the extent to which efficiencies across business and human resource process will be gained from the Transformation.

In light of the ongoing implementation of WHO transformation, coupled with the constraints imposed by the COVID-19 pandemic, it is understandable that robust evidence of enhanced WHO country office operations, let alone evidence of increased impact at country level, has not been forthcoming: despite the appreciation expressed by individual WHO representatives for the enhanced support provided by WHO regional office or headquarters, with the exception of the African Region, transformation has not yet fully reached WHO country offices, for whose work the change process has been undertaken in the first instance. There are some indications of positive momentum in this area: in addition to the gradual increase of resources in regional offices described above, WHO has been progressively building its partnerships for greater impact at country level, for example, through a number of WHO country offices reporting an increase in their engagement in United Nations country teams, through the Organization's coordination of the Global Action Plan for Healthy Lives and Well-being for All and the continued strengthening of this partnership at country level.

Lack of outcome-level milestones of Transformation activities

In a formative evaluation such as this, the lack of robust evidence for outcome-level change, whether at country level or at regional or headquarters levels, is not surprising. In the case of WHO transformation, however, this evidence gap is rooted not only in the ongoing status of the initiative's implementation but rather in a wider shortcoming: the lack of clear metrics for measuring and reporting on the outcome-level results being targeted by the various initiatives pursued under the workstreams. Thus far, monitoring and reporting efforts have focused on implementation status, which provides a very basic gauge of outputs and activities undertaken to date, and on the Output and Balanced Scorecard, which some staff maintain has fostered a more results-oriented culture but others claim is overly cumbersome with little practical use in their day-to-day operations.

Put simply, the precise milestones for how – and by when – WHO can be considered to be transformed (that is, nimbler, more fit for purpose, more modern, and so on) as a result of the various changes being undertaken have yet to be defined, tracked or reported against. Moreover, a precise and comprehensive indication of the inputs expended on transformation (monetized staff time as well as financial resources) are not available in one central location, rendering a planned gauge of the overall return on investment of the initiative unfeasible to date. Efforts are reportedly being undertaken to remedy this gap in 2021 and should continue – in tandem with a clear and comprehensive theory of change or logic model described above – as these will be useful to the WHO Secretariat as a management tool and to Member States, who are interested in following WHO transformation and its outcomes more closely.

CONCLUSION AND WAY FORWARD

WHO transformation is not the first reform of WHO to be undertaken, nor is WHO the only organization within the United Nations system currently undergoing a significant reform initiative. It is, however, unique in its reach and ambition of repurposing WHO to become a more modern, seamless, impact-focused Organization that is better equipped to help Member States achieve the health-related Sustainable Development Goals by 2030.

The far-reaching scope and scale of the specific organizational changes launched by the Transformation has been correspondingly ambitious, and the context in which they have been pursued has been exceedingly challenging. These changes have entailed seven workstreams encompassing 40 distinct initiatives aimed at addressing both the “hard-wiring” aspects of change (that is, fundamental structural

and process changes) and others the “soft-wiring” aspects (that is, changes to its organizational culture that have long been viewed as deep-rooted and difficult to address), and many of these initiatives have been pursued in parallel to each other. They have also been pursued within WHO’s singularly decentralized structure, a feature of the Organization that poses unique challenges for any corporate initiative, not least of all change management initiatives. Further compounding these challenges, less than two years into transformation, its implementation risked being derailed by the unprecedented disruption of the COVID-19 pandemic in which WHO has played a leading role.

Within this context, progress in implementing this ambitious change initiative has been significant despite the constraints, even if such progress has been somewhat slower or less pronounced in some key workstreams than in others. To date, however, it appears that most of this progress has primarily been at the activity and output level, and primarily at headquarters and in some regional offices. Far less is known about the tangible effects that the changes implemented to date have had on the functioning of the Organization, however – or on the extent to which they have contributed to the end goal of increasing WHO’s impact at country level.

This lack of evidence for results on the Organization’s functioning is partly rooted in the inherently long arc of large and ambitious change management initiatives such as transformation, and in the challenging operational environment in which transformation has taken place – but only partly so. At a fundamental level, whereas the design of transformation benefitted from a wide range of inputs – from an inclusive approach to staff consultation, from lessons learned from previous reform efforts, and from the state of the knowledge on organizational change – it lacked a comprehensive, coherent roadmap (that is, a theory of change or logic model) that clearly and concretely articulates what the desired end state of being transformed “looks like” and precisely how the elements of WHO transformation will work together toward this desired end state. By extension, there has also been a lack of corresponding metrics for measuring and reporting on the outcome-level results being targeted by the various initiatives pursued under the workstreams, the significant inputs expended on the various initiatives associated with the workstreams. Put simply, the precise milestones for how – and by when – WHO can be considered to be truly transformed (that is, nimbler, more fit for purpose, more modern, and so on) and what the level of investment has been to achieve these milestones have yet to be defined, tracked or reported against.

The lack of a theory of change and corresponding outcome-level indicators has internal implications for the Secretariat’s ability to manage the change process in a well-informed, evidence-based manner. It also has implications for the Secretariat’s ability to communicate openly and transparently on transformation to Member States, who feel they could have been better engaged during the transformation process or better informed on key areas of relevance to the exercise their role and strategic responsibilities within the Organization: what the overarching plan is, what the desired end state is and when WHO will know it has achieved it, what is and is not being achieved through implemented initiatives, and what transformation is costing.

With the COVID-19 pandemic response very gradually ceding space to other areas of concern to the Organization, now is an opportunity to consolidate WHO transformation gains made to date, get back on track with those initiatives that are farther behind than others, redouble the focus on outcome-level change (not least of all at country level), and to address the areas for improvement highlighted in the evaluation. Doing so will maximize the likelihood that the investment of WHO’s human and financial resources on this crucial organizational change initiative will ultimately yield the targeted result – increased impact at country level – with all key stakeholders having a clear, shared sense of the way forward.

RECOMMENDATIONS

The evaluation makes five recommendations that aim to address the areas for improvement outlined in the report and, in keeping with the formative focus of the evaluation, these recommendations aim to enable the full and consistent implementation of the WHO Transformation moving forward. Roughly structured according in their order of criticality, these are as follows.

Recommendation 1: The WHO Secretariat should establish clear and comprehensive outcome-level milestones for the remainder of WHO transformation and use these measures as an internal management tool and as a communications tool for reporting on progress.

Building on the inferred theory of change developed for this evaluation, the WHO Secretariat should:

- a. revise this theory of change, as necessary, to make it as comprehensive and meaningful an encapsulation as possible of the results road map for transformation – that is, the desired end state sought by the initiative, how the various workstream initiatives are intended to contribute to each outcome both individually and jointly, the inputs (human and financial resources, partnerships), and the assumptions and risks to be managed in the final stage of WHO transformation;
- b. operationalize the theory of change in a series of specific, measurable, actionable and attainable, relevant, and time-bound (SMART) outcome-level milestones (that is, key performance indicators), accompanied by corresponding timeline milestones for when it is expected that targeted outcome-level changes will be fully realized, bearing in mind the assumptions identified in the theory of change;
- c. aim to maintain a record of the human and financial resources expended on transformation throughout the Organization so that there is a clearer picture of the organizational investment in the initiative; and
- d. use the theory of change and accompanying metrics to monitor and report on progress moving forward.

Recommendation 2: The WHO Secretariat needs to engage its Member States better throughout the remainder of WHO transformation's implementation.

In this regard, priority should be placed on:

- a. clearly and transparently communicating the results road map encapsulated in the theory of change, including what organizational initiatives are and are not directly a part of the transformation;
- b. regularly providing Member States with clear updates on progress made (including progress not made) against the implementation plan as well as targeted outcome-level changes;

- c. Consulting with Member States, as appropriate, on any ongoing or new/emerging transformation-related initiatives.

Recommendation 3: Without losing momentum for continued progress at all levels of the Organization, the WHO Secretariat should invest dedicated attention – and resources – towards supporting country-level transformation in the next phase.

With emphasis having thus far been on changing operations at headquarters and, in some cases, regional offices, in the next phase attention must redouble its focus on the end goal of this organizational change initiative and the GPG's vision of a strengthened WHO country presence: transforming country offices and transforming supports to country offices in order to realize WHO's vision for country-level impact. Towards this end, the WHO Secretariat should prioritize the following measures:

- a. The Programme budget 2022–2023 should allocate adequate resources to country-level operations and, once this is approved, WHO country offices should be encouraged to better apportion their resources towards making larger country-level impacts and fully realize the GPG aspirations for the WHO country-level presence and operating model.
- b. Specific targets should be established for the number of positions increased (moved or newly created) in country offices.
- c. Further investments in the WHO representative selection and development process should be made in order to ensure strong competencies in leadership, management, advocacy, resource mobilization and multi-sectoral partnership work.
- d. Based on the finalized theory of change for WHO transformation, any additional measures that are necessary for improving transformation at country level and the supports for country-level impact from other corners of the Organization should be identified and pursued.

Recommendation 4: Efforts should be intensified to build a motivated and fit-for-purpose workforce.

As a crucial means of advancing multiple goals conducive to the success of WHO transformation – for example, circulating knowledge across the three levels of the Organization, forging a “One WHO” identity within its organizational culture, fostering a heightened sense of how country offices operate and what supports they need in order to enable their work, and cultivating a motivated and fit-for-purpose workforce, the WHO Secretariat should:

- a. prioritize implementation of the reforms in human resources, including the development of WHO career pathways, enhancing contracting modalities and the implementation of global geographic mobility; and
- b. to promote staff mobility and rotation, when filling all new positions or replacement vacancies, consider if the position in question can be located at decentralized level without the loss of overall organizational effectiveness to WHO. Hiring managers should either

move the position to the field or explain why it should not be moved to the field, in keeping with the “comply-or-explain” principle.

Recommendation 5: The WHO Secretariat should accelerate the pace of desired changes in its organizational culture.

The WHO Secretariat should consider the following actions to accelerate and embed desired cultural shifts throughout the Organization:

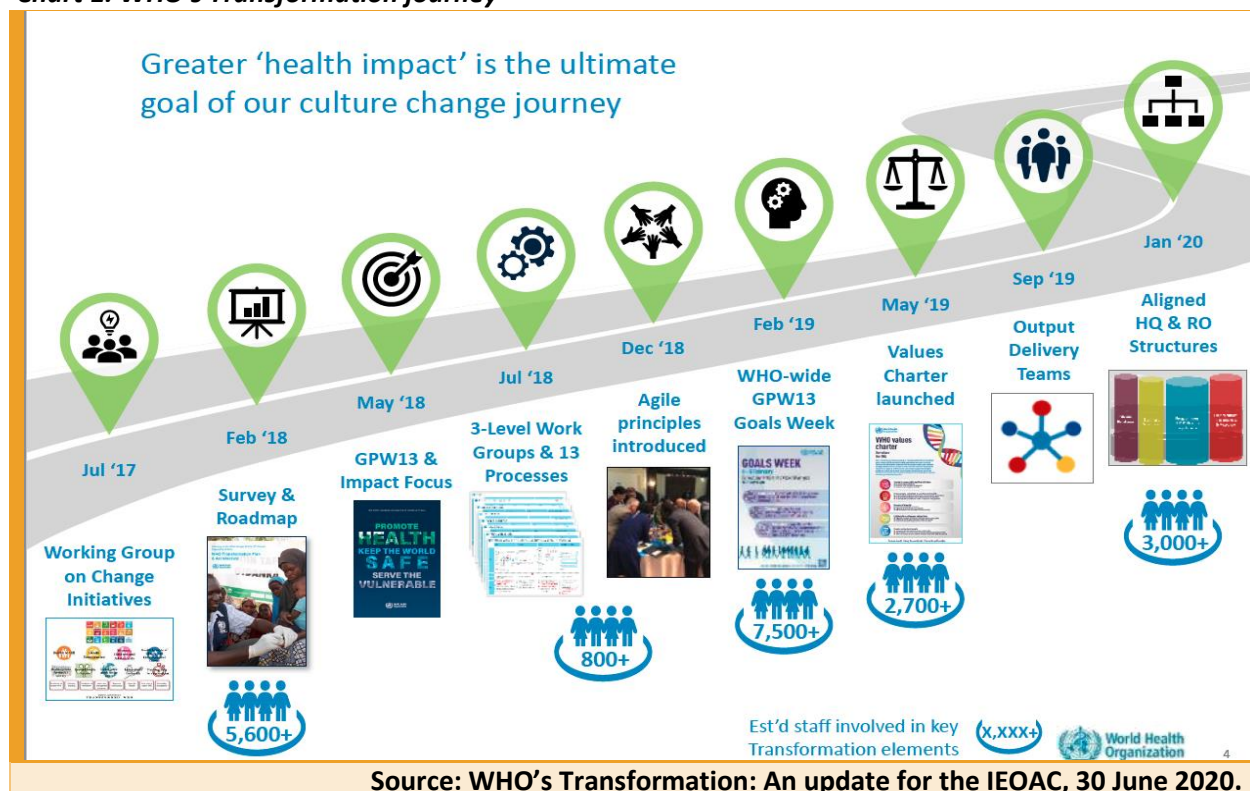
- a. Building on initiatives such as the WHO Academy and the leadership training initiative of the Regional Office for Africa, the WHO Secretariat should escalate its investment in leadership and professional skills development at all levels of the Organization, but especially among WHO representatives and managers elsewhere. Leadership initiatives should incorporate the cross-cutting priorities of gender equity and empowerment and diversity and inclusion.
- b. Actions such as the Director-General’s open-door policy should not only be modelled at the top but also promoted by managers at all levels of the Organization. Regular feedback, including by documenting and responding to relevant proposals submitted by staff, should be considered a central element of this strategy.
- c. A more concerted effort needs to be made to align policies and procedures with the new norms of collaboration and agile functioning.

1. INTRODUCTION AND METHODOLOGY

1.1. BACKGROUND

The World Health Organization (WHO) Transformation was launched in July 2017 with the establishment of the Working Group on Change Initiatives, and broadly communicated with the release of the *WHO Transformation Plan & Architecture* in February 2018 by the Director-General.¹ WHO's global strategy and targets for Sustainable Development Goal (SDG) achievement at the country level, documented within the 13th Global Programme of Work (GPW 13), were seen as bold and ambitious and requiring the organization to optimize its use of resources, streamline processes, and ensure it is fit for purpose in a rapidly changing world. As such, and as stated in the terms of reference for this evaluation, the goal of Transformation is to “make WHO a modern, seamless, impact-focused Organization to better help Member States achieve the health-related SDGs in the context of United Nations reform.” It is the latest in a series of change management and reform initiatives that WHO has undertaken over the years.² Chart 1 provides a chronological overview of key milestones in the Transformation process, as presented by WHO in June 2020.

Chart 1. WHO's Transformation journey



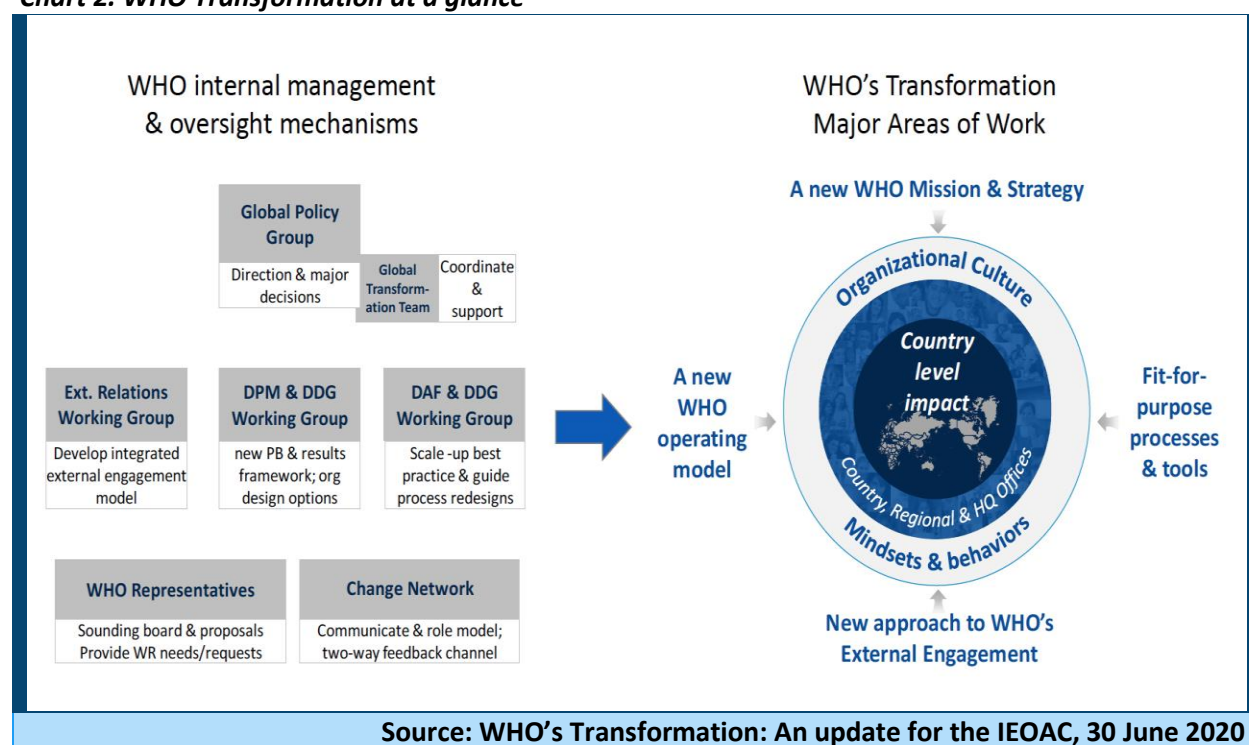
¹ WHO (2018). [WHO Transformation Plan & Architecture](#), 16 February 2018.

² The previous most recent reform process began in 2011, and was evaluated in three stages (2012, 2013 & 2017).

The Transformation was undertaken in four phases. The first phase, spanning from July 2017 to February 2018, consisted of consultations and analytics and culminated in the *WHO Transformation Plan & Architecture*.³ It informed the Global Policy Group (GPG) deliberations and the Director-General's decision-making. The second phase on Design (strategy & results, processes, operating model), spanning from February 2018 to March 2019, led to the development of GPW 13, the redesign of 13 key WHO processes and a new WHO wide operating model. The third phase, from March to December 2019, focused on alignment and initiated changes to organizational structure, ways of working, and the development of the WHO Values Charter. The fourth and last phase on implementation and continuous improvement started in January 2020. It is ongoing and it was marked by the roll-out of new Headquarters (HQ) and Regional Office (RO) structures, a new programme budget (PB 2020-21) and related 3-level processes.

The Transformation was initially structured around five broad workstreams: a new strategy, a new operating model, fit-for-purpose processes and tools, strengthened organizational culture and staff engagement, and new external engagement and partnerships. Two additional cross-cutting and enabling areas of work – predictable and sustainable financing and building a fit-for-purpose workforce – were added in 2019. Chart 2 provides an overview of the internal management and oversight mechanisms for the Transformation and major areas of work.

Chart 2. WHO Transformation at a glance



The changes to the internal functioning of the Secretariat, across all major offices, aim to increase the results orientation of WHO's strategy as outlined in its GPW 13. These changes entail the redesign of the 13 key WHO processes that underpin the strategic shifts of the GPW 13, such as towards ensuring the quality and impact of WHO's normative work. These process redesigns are currently being rolled out

³ WHO (2020). WHO's Transformation: An update for the IEOAC, 30 June 2020.

across various offices. Transformation also envisages revamping the entire ‘set-up’, or operating model, of WHO to better deliver GPW 13 at each level (i.e., WHO country offices (WCOs), ROs and HQ). It seeks to align the structure of all offices along four major ‘pillars’ as well as establishing a Chief Scientist function, and adopting new and integrated ways of working, anchored in ‘Output Delivery Teams’, to more efficiently and effectively respond to Member States’ needs. Lastly, recognizing the importance of partnership for achieving the UN’s SDGs, it aims to develop a new approach to leveraging relationships with a broader range of actors.

Much of the work on the Transformation, including re-aligning the HQ and regional major offices to the 4 pillars of the new, 3-level operating model, was reportedly completed in late 2019, while other aspects, such as changing the organizational culture to be more agile, collaborative and results-oriented, are still ongoing. A summary of major initiatives and milestones is included in Annex III for the ease of reference.

1.2. EVALUATION OBJECTIVES AND SCOPE

The 2020-2021 biennial evaluation workplan – which was developed in consultation with senior WHO staff, considered by the Independent Expert Oversight Advisory Committee (IEOAC) at its meeting in October 2019, and approved after review by the 146th session of the Executive Board – called for an *evaluation of the WHO Transformation*. In pursuance of this workplan, Terms of Reference were developed for the evaluation (see Annex I).

The overarching objective of this evaluation was to assess progress of the WHO Transformation to date and the status of implementation of the *WHO Transformation Plan & Architecture*. More specifically, the evaluation was tasked with:

- (a) documenting key achievements, best practices, challenges, gaps, and areas for improvement in the implementation of WHO transformation thus far;
- (b) assessing whether change management issues and barriers to implementation have been appropriately considered and addressed; and
- (c) making recommendations, as appropriate, on the way forward to enable the full and consistent implementation of WHO transformation.

This was a formative evaluation planned with the intent to derive lessons to help propel the purpose and implementation of the Transformation forward so that it is ultimately as successful as possible. The main audience for this evaluation is the GPG, the Global Transformation Team, the Change Network members, and the Business Owners of the Transformation initiatives. However, given that this initiative has implications for all staff, Member States and other stakeholders, the audience for the evaluation encompasses all internal and external stakeholders of WHO.

WHO’s Independent Expert Oversight Advisory Committee was engaged and was regularly apprised of the evaluation’s progress throughout the process. An evaluation reference group (ERG) consisting of colleagues from all three levels of the Organization and all seven major offices was established to inform and support the evaluation in an advisory capacity.

Evaluation Scope

The evaluation covered the design and implementation of the WHO Transformation across *all levels* of the Organization. The evaluation exercise was guided by the main evaluation criteria of design, relevance, coherence, efficiency, effectiveness, sustainability and impact, as well as gender equity and human rights. It provides information on the progress on implementation of the Transformation workstreams; the processes put in place, the outputs generated, and the impact on organizational values and culture; enabling factors and challenges encountered; and the overall effectiveness and impact of the Transformation on the work of the Organization. In light of WHO's heavy involvement in the ongoing COVID-19 pandemic, the evaluation also considered the impact of Transformation on WHO's ability to respond to such pandemics as well as, conversely, the impact of the pandemic on WHO Transformation.

The period covered by the evaluation was from July 2017, when the Transformation process was initiated, to March 2021 when the data collection phase ended. With respect to geographic scope, the evaluation assesses results relevant to the Transformation at the three levels of the Organization. Given the decentralized nature of WHO, it was important to assess regional and country-level variation.

1.3. METHODOLOGY

This formative evaluation was conducted in four phases: (1) inception; (2) data collection; (3) data analysis; and (4) reporting. The evaluation timeline spanned August 2020 to April 2021, culminating in the submission and presentation of the evaluation report by the DeftEdge (DE) evaluation team.

Inception Phase

The inception phase was undertaken in August-October 2020. It started with a review of key foundational documents (e.g., the GPW 13, the WHO Evaluation Practice Handbook), as well as all relevant Transformation documents available at that time (e.g., the Transformation Architecture and Plan, progress reports, programme documents, internal review reports, diagnostic studies, budgets, financial reports, needs assessments, diagnostic reports, organizational health and pulse surveys, and other material provided by WHO and stakeholders consulted). While the list of key documents reviewed is included in Annex VIII, the complete list can be obtained from the Evaluation Office.

This phase also included remote consultations with 33 key stakeholders at all three levels of the Organization, to understand the vision, needs, strategies, plans and actions undertaken for the Transformation, as well as the context in which the Transformation unfolded. With the support of the WHO Evaluation Office, DE engaged WHO's senior management, the Transformation Team, the ERG, consulting firms engaged in shaping the Transformation processes, focal points and other stakeholders involved in the implementation of the Transformation, and members of the IEOAC. In addition to providing the requisite background information on the subject at hand, these consultations helped shape the scope of evaluation and the tools and methodologies to be used.

The inception interviews indicated that a vast majority of the work has thus far focused on action at HQ, and to a lesser degree in ROs and WCOs. The timing and timeline of this evaluation has implications for the scope and methodology and for what can reasonably be concluded at this stage. That said, the timing of the evaluation also provides a positive opportunity to take a formative, constructive approach – one that will equip WHO with information on its progress to date that enables it to capitalize on its achievements while also reflecting on, and course-correcting, identified gaps or risks and recalibrating the remainder of the Transformation’s implementation, as necessary.

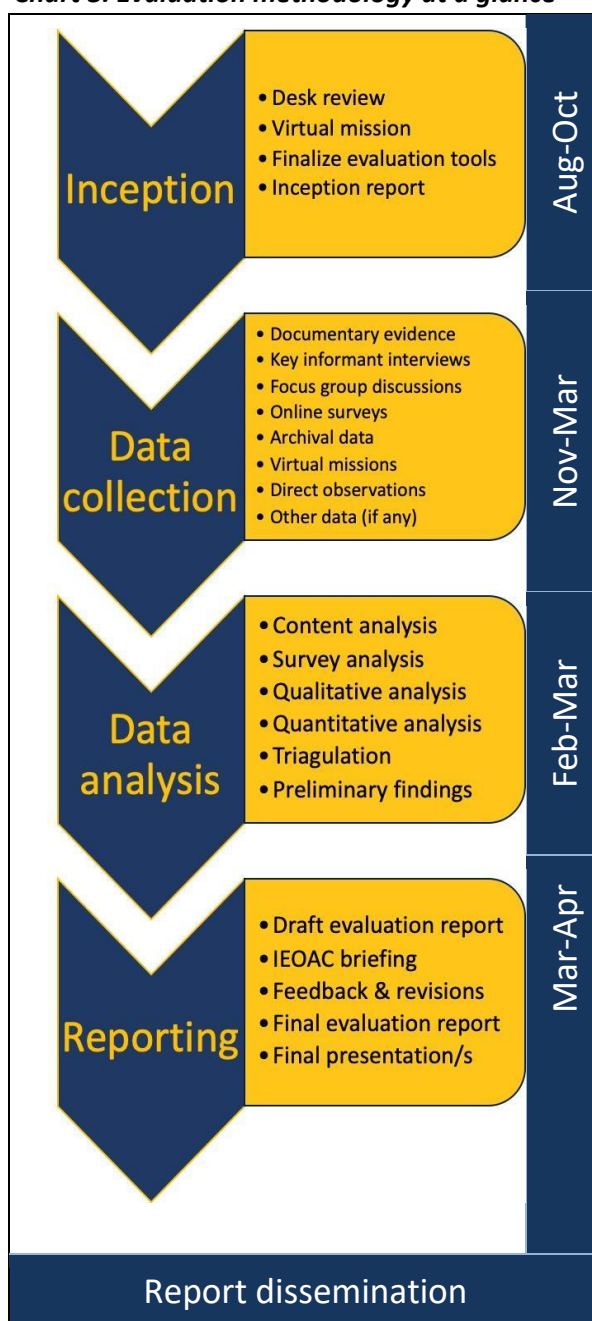
While the temporal proximity of the present evaluation to the implementation of the Transformation somewhat limits the outcome and impact-level results that it can be expected to observe at this early stage, the evaluation team put together a theory of change and associated evaluation results matrix (Annex V) that served as guideposts to observe WHO’s progress towards likelihood of these results materializing in due course. By observing specific milestones at specific points in time, as well as explicitly stating underlying assumptions, these guideposts could serve to indicate the need for course corrections along the way. A focus group discussion with the ERG was undertaken to validate the theory of change. Given its significance for the evaluation, it is described in the next section.

A draft inception report, which was reviewed by the ERG, was the primary output of the inception phase. This phase helped translate the overarching evaluation objectives articulated in the terms of reference into specific evaluation questions and define the overall evaluation, approach and methodological tools, including survey instruments and interview protocols (Annex IX).

The two main overarching questions articulated at this stage were as follows:

1. To what extent has WHO transformation, in its overarching design and in its specific elements, been **relevant to meeting the organizational reform and change management objective of being fit fo purpose**, as envisaged for the Organization at this juncture in its evolution?
2. How **effective has WHO transformation been thus far** in delivering on its targeted actions according to plan and in orienting WHO towards the achievement of its intended outcome-level

Chart 3. Evaluation methodology at a glance



and impact-level results? What have been the key results achieved, best practices, challenges, gaps, and areas for improvement? How likely is transformation to contribute to the achievement of the goals outlined in GPW 13 and the SDGs?

Each of these evaluation questions was further operationalized by a series of sub-questions. The evaluation also included a range of cross-cutting questions pertinent to the evaluation objectives (e.g., facilitating factors and barriers affecting the Transformation's implementation to date; how adeptly WHO has leveraged its human, financial, technical and technological resources to maximize the Transformation's success in the most efficient, internally consistent and coherent, whole-of-organization manner; and gender, equity and human rights considerations (See Annex II for evaluation questions).

A virtual inception mission gave the evaluation team an opportunity to communicate the scope and objectives of the evaluation to key stakeholders as well as to get insights from them and clarify and manage expectations for this evaluation. Chart 3 provides a more detailed overview of the methodology used.

Data Collection Phase

The second phase of the evaluation — data collection — officially began upon the approval of the inception report. Using the tools outlined earlier in the report, data collection from various sources and methods was undertaken concurrently. It involved documentary evidence, virtual consultations by way of key informant interviews (KIIs) and focus group discussions (FGDs), online surveys, direct observations, archival data sources (e.g., web analytics, processing times, etc.), and other data as needed and available.

Desk review: All important documents were formally reviewed to harvest outcome data. In addition to key documents listed in Annex VIII, the evaluation team reviewed a large number of supplementary documents as needed. In total, more than 500 documents were reviewed. The shared aim of the desk review was to provide concrete documented evidence to help answer the evaluation questions. For example, diagnostic reports produced by consulting companies, previous evaluation reports and meeting minutes noted in the Annex VIII were reviewed and coded against the outcomes identified in the evaluation matrix. Thus, answers to evaluation questions related to the extent of the Transformation's implementation to date were aided by a review of progress reports, memos to the Director-General (DG), minutes and reports of status update meetings.

Virtual stakeholder consultations: The informed opinion of staff and senior management across the three levels of the Organization and Member States is crucially important. Owing to current travel restrictions, all consultations were conducted remotely. This was sought by means of key informant individual and group Interviews (KIIs) and FGDs which provided rich, in-depth qualitative information on all aspects of the Transformation. This subjective assessment of participants, who live through the experience on a daily basis, was triangulated through other data collection methods. These semi-structured consultations were conducted using protocols (Annex IX) that were tailored according to the role and involvement of the specific stakeholder(s) consulted. In addition to common questions outlined in the protocols, interviewers probed deeper into issues that emerged during the interviews.

In total, 121 persons were consulted through KIIs and 14 group interviews and 107 persons through 17 focus group discussions conducted internally – including with the staff associations in HQ and in the regions, the G-Force at HQ and 10 WCOs – and externally with Member States in three focus groups in which 46 Member States were represented (from the Region of the Americas and the European, South-

East Asia and Western Pacific Regions). Each KII lasted about an hour and each FGD and group interview approximately 90 minutes. Some stakeholders, especially members of the Transformation team, were consulted more than once during the process.

The evaluation team interviewed a wide swath of stakeholders, either individually or in small groups. These consultations, identified on the basis of a comprehensive stakeholder mapping exercise (Annex VI), strove to achieve optimal geographical and gender balance with a view to capture the voices of all key stakeholder groups (Annex VII provides a detailed list of stakeholders consulted).

Archival data: The evaluation team collected relevant archival data from various organizations and units, including data such as information on human resources, finances, and business processes over time.

Direct observations: The evaluation team remotely observed key meetings and events pertaining to the Transformation that occurred during the data collection phase for direct observation. These included WHO Town Hall on Transformation (Nov 2020), all-staff ‘open-house’ on flexible working arrangements (Dec 2020), and a Joint Rotary International/WHO virtual event on the theme “Together for mothers’ and children’s health” (Feb 2021).

Online surveys: The evaluation team developed and launched an online staff survey sent to all staff in English, French and Spanish, to collect data on outcomes identified in the evaluation matrix. This survey also included questions on organizational culture, which is one of the key cross-cutting transformations underpinning most of the outcome-level results sought by WHO. This survey included key questions from the culture survey conducted by McKinsey Consulting in 2017-18, which provided the baseline data to measure progress. In accordance with the guidance of the WHO Evaluation Office, the staff survey invited all WHO staff to participate in the survey, rather than a sample subset. In total, 1287 staff members (14% of WHO staff⁴) responded to the staff survey. Statistical analysis showed that HQ staff was slightly over-represented in the survey sample, while staff in Africa and the Americas were slightly under-represented (Chart A1 in Annex X). However, the differences were not statistically large enough to affect the validity or reliability of the survey results in a significant manner. Hence, in consultation with the Evaluation Office, it was decided to report data disaggregated by regions rather than weight the survey data to adjust for these slight differences. Staff from across all major offices and all three levels of the Organization participated in the survey. More detailed information on the staff survey sample is provided in Charts A1-A4 in Annex X.

Structured questionnaires: Two short questionnaires, aimed at getting focused inputs of Member States and heads of WHO offices in countries, territories and areas⁵ on progress with respect to outcome results from their perspective, were also administered. For Member States, the questionnaire was distributed in the six official languages of the Organization through an official list of email addresses provided by the Governing Bodies Department and heads of country offices were also informed to encourage participation. 23 Member States,⁶ representing five regions, and 14 heads of country offices responded to these questionnaires. Member States and heads of country offices were also invited to request a one-on-one interview should they so desire, and one Member State and two heads of country office availed themselves of this option.

⁴ 1,287 out of 9,195 staff members (including AMRO staff).

⁵ Heads of country offices were also invited to participate in the all-staff surveys. They were given the option to complete a shorter survey given their other time commitments during the ongoing pandemic.

⁶ A 24th Member State provided a response but was not included in the analysis as it was received after the report was drafted.

Overall, the evaluation followed a mixed-methods, inclusive and participatory approach with systematic triangulation against baseline measures to arrive at the most objective, impartial and credible findings possible. It was carried out in accordance with United Nations Evaluation Group (UNEG) norms and standards and the *WHO Evaluation Practice Handbook*. The evaluation team used a strict protocol on code of ethics, in alignment with UNEG Ethical Guidelines and Code of Ethics for Evaluators. This included ensuring that all data from interviews was kept confidential and secure, that interviews were conducted in a professional and responsible manner, and that team members were impartial and had no conflicts of interest. The evaluation process aimed to be human rights- and gender-responsive. Toward this end, there were evaluation questions specific to gender and human rights, groups from all levels of staff and from different sized countries in all regions were consulted, and attention was paid to ensuring all voices were heard in group discussions. In total, 46% of individual and group interviewees were women. In addition, particular attention was paid to human rights and gender equity issues in the analysis, findings, conclusions and recommendations.

Data Analysis and reporting phase

The third phase involved data analysis and reporting. This phase was ongoing, beginning with the document review and collection of data through KIs, FGDs and surveys. Qualitative and quantitative analytical techniques were employed. Content analysis was used to convert content from the documents and interview notes into quantitative data according to the evaluation matrix. Graphics and statistical analysis are used to help visualize data and explore significance of findings.

Evaluation Limitations

The COVID-19 Pandemic: The evaluation was carried out during the pandemic. This necessitated all data gathering to be conducted remotely which, to some extent, limits the richness of data collected compared to in-person interactions and field observations. This was also an extraordinary time for WHO which, understandably, affected the availability of some staff for interviews and the survey. To address this, the evaluation team carried out data collection over an extended period to enable rescheduling as needed. In cases where additional information was needed, this was collected through follow-up call and emails. The Evaluation Office also played a key role in ensuring a reasonable participation rate by personally reaching out to potential interviewees and sending survey reminders.

Survey Response Rate: The surveys capture the daily lived experience of respondents. Though, the response rate to all three surveys and questionnaires was somewhat low, it is comparable with the previous evaluation of WHO reform (2011-2017) conducted by PwC in April 2017, which was also responded to by around 1200 staff members.⁷ Note also that this response rate is in line with other organization-wide surveys that are administered (i.e., sent out) by the evaluand (i.e., organization/entity being evaluated).⁸

It is also worth noting that the profile of respondents to all instruments nonetheless represented a wide swath of each of these groups, and the survey respondent profile closely mirrored that of the overall staff profile (See Chart A1 in Annex X). Statistical tests showed that there was no reason to believe that the

⁷ The evaluation report did not provide the actual number, but mentioned in the cover letter to the report that, “We also conducted an online staff survey of close to 1,200 WHO staff”.

⁸ The survey used DeftEdge data collection system, but was sent out by WHO Intranet administrator/s.

profile of staff members in general was different from that of respondents. Moreover, results on the culture survey were almost identical to that on the previous culture survey that was *administered by McKinsey* in Nov 2017 (and reported in early 2018). This survey had elicited a much higher response rate of around 66%. Hence, there is no reason to believe that the lower response rate to be a major concern for this evaluation.

Further, questions on various elements of Transformation were presented on the basis of self-reported knowledge of Transformation. The staff respondents, who were less familiar with the Transformation, were directed to the organizational culture section of the survey without being asked to answer questions about a topic of low familiarity to them. In this vein, it is important to note that the number of these respondents lacking familiarity with the Transformation constituted a significant minority of the total number of respondents. This represents a significant evaluation finding in its own right: even for those staff members willing to take part in a survey on the Transformation, awareness of this pivotal initiative for the Organization – over three years into its implementation – is low.

While all findings outlined below are triangulated against multiple data sources and methods, and appropriate statistical significance of findings is noted where relevant, the results of any one study should be cautiously interpreted.

Evaluation Scope: The extensive scope of the exercise, which includes the entire Transformation initiative across all levels and regions of the Organization, limits the extent to which an in-depth assessment at the level of regions, initiatives and workstreams can be conducted. The focus of this evaluation is on the birds-eye view of the entire Transformation. WHO could and should evaluate each of the dozens of Transformation initiatives separately to understand their effectiveness at a more microscopic level.

2. THEORY OF CHANGE

As indicated in the previous section, one of the key outputs of the inception phase was to develop a Theory of Change and associated evaluation results matrix for the Transformation. This theory of change serves as a means of establishing a shared understanding among all key stakeholders of what the Transformation has sought to accomplish and how it has sought to do so. It also serves to guide the evaluation team in ensuring that all of its members have this shared understanding and that, by extension, they cover all key aspects of the Transformation in responding to the evaluation objective, which was to assess progress of the WHO Transformation to date and the status of implementation of the WHO Transformation Plan & Architecture. This Theory of Change was developed on the basis of results chain analysis (Annex IV), and, as indicated earlier, *was validated with key stakeholders, including members of the Transformation Team and the ERG.*

Chart 4 provides the visual representation of the Theory of Change, which is discussed below in the order of logical chain from the right-side (intended impacts/ultimate goal) to the left-side (inputs and outputs).

As discussed in the results chain analysis, WHO's mission is "the attainment by all peoples of the highest possible levels of health." While GPW 13 outlines achievement of the goals⁹ as three pillars (and ultimate impact-level targets) of WHO's work, the *overall objective of the Transformation* itself is an instrumental one toward this end, namely as follows:

"More modern, seamless and impactful World Health Organization for achieving the triple billion goals as outlined in its 13th General Programme of Work (13GPW) and health-related SDGs as reflected in UN's 2030 Agenda for sustainable development."

As more "modern, seamless and impactful" organization cannot be measured, this really refers to the increased effectiveness, efficiency and fit-for-purpose of WHO.

This instrumental objective fully captures the intent of WHO's Transformation as reflected in multiple documents reviewed during the inception phase. Further, based on the Theory of Change developed during the inception phase, the specific objectives to realize its triple billion goals, overall functioning of WHO and new approach to partnerships, are as follows:

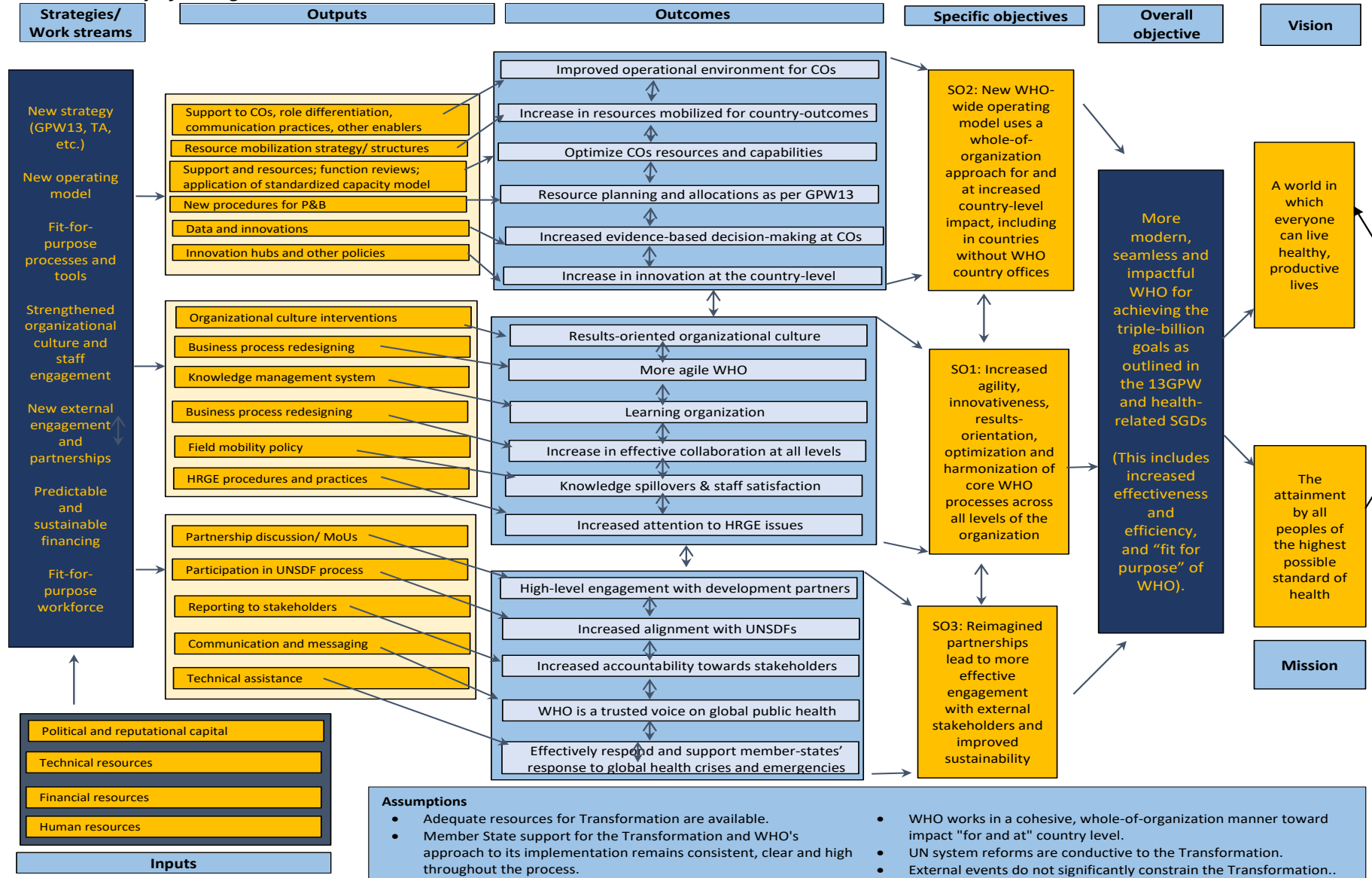
Specific Objective 1 (SO1): Increased agility, innovativeness, results-orientation, optimization and harmonization of core WHO processes across all levels of the Organization.

Specific Objective 2 (SO2): New WHO-wide operating model uses a whole-of-organization approach for and at increased country-level impact, including in countries without WHO country offices.

Specific Objective 3 (SO3): The new approach to partnerships leads to more effective engagement with external stakeholders and improved sustainability.

⁹ These are: 1 billion more people benefitting from universal health coverage. 1 billion more people better protected from health emergencies. 1 billion more people enjoying better health and well-being.

Chart 4. Theory of Change



To reiterate, according to various Transformation documents, the first objective is focused on WHO as a whole. The outcomes associated with this objective therefore pertain more broadly to changes to the way WHO operates, including greater agility, innovativeness, results-orientation, optimization and harmonization of core WHO processes. This objective pays special attention to both changing organizational culture and business processes in order to make WHO a more “modern” organization, better equipped for the task at hand – one that is driven less by hierarchy and more by effective collaboration for achieving the ambitious agenda outlined in GPW 13 and the health-related SDGs. Reducing hierarchical levels, cutting down on time spent on administrative processes, better knowledge management, increased staff mobility and associated knowledge transfer and spillovers, and increased results-orientation are some of the key outcomes sought to realize this objective.

The second specific objective seeks a new WHO-wide operating model that enables Member States, including where there are no WCOs, in making the intended impact in their specific country contexts. It includes strengthening of WCOs and country-level work. Some of the outcomes sought under this objective are improved operating environment, improved support from regional offices and HQ, improved support functions within the WCOs, better resource allocation, mobilization and optimization according to GPW 13, increased use of data and innovations, and evidence-based decision-making at the country level. While some of these results are common to all levels of WHO (as mentioned in SO1), WCOs and ROs that serve countries in which there is no WHO presence are expected to be at the frontier of delivery on triple billion goals. Therefore, the evaluation seeks to specifically examine changes in this regard as a result of the Transformation at the country level. There are 149 offices in countries, territories and areas in the 194 Member States, and for the remaining countries, they are expected to be covered by the respective regional offices. Information on those countries was obtained through consultations with the regional offices.

As WHO cannot achieve its ambitious goals by itself, the third objective focuses on leveraging partnerships to maximize results. Responding to UN reform processes, increased coherence within the UN system and alignment with United Nations Sustainable Development Cooperation Frameworks (UNSDCFs)¹⁰ are some of the primary desired outcomes. Additionally, high-level engagement with donors, collaborators and other development partners – including non-State actors (NSAs) – are outcomes sought. However, even more significantly, WHO needs to be seen as an authoritative voice on public health issues and its response to public health emergencies needs to be seen as effective if it is to build, sustain and leverage these partnerships. Thus, achievement of these outcomes is key to the success of WHO on its third specific objective.

To achieve these objectives and the outcomes subsumed under them, WHO has ostensibly made significant investments of time, resources and efforts in seven workstreams (which, as stated above, include: a new strategy, a new operating model, best-in-class processes and tools, strengthened organizational culture and staff engagement, new external engagement and partnerships, predictable and sustainable financing, and building a fit-for-purpose workforce). From the desk review and inception interviews, it has been clear that these workstreams map specifically and directly to the Transformation Specific Objectives.

This theory of change makes a number of key assumptions upon which the ultimate success of the Transformation rests – that is, those conditions which must be in place for the Transformation to be

¹⁰ Formerly United Nations Development Assistance Frameworks (UNDAFs).

successful. These include the assumption that there is no major change in membership and contributions and that expected resources are available or can be raised. It also assumes that the unforeseen challenges such as the ongoing pandemic do not divert WHO's attention and resources away from Transformation to more pressing immediate needs. It also assumes that WHO's decentralized structure can be managed – and possibly even harnessed – to achieve a sufficiently cohesive, coherent and harmonized whole-of-organization approach in working toward its shared goals in the Transformation. Similarly, UN agencies with different mandates can be brought together to function in a cohesive manner.

Whereas the evaluation questions and associated methods describe *how* the Transformation was evaluated, the evaluation matrix and theory of change detail *what* precisely was being evaluated (i.e., the unit of analysis): how the various strands of the Transformation add up to form a multi-pronged, coherent reform and change management initiative that aims to position WHO at all three levels of the Organization to achieve results targeted by the GPW 13 and the health-related SDGs. Toward this end, this evaluation matrix encapsulates the essence of results targeted by WHO. It also provides a detailed overview of how various actions and outputs are expected to lead to outcomes envisaged and what indicators will be used to measure progress towards those outcomes. In addition, the evaluation matrix provides an overview of data collection methods and sources. The matrix also tries to unpack some of the key assumptions, and associated risks and unintended results, that undergird the logical framework.

The next section discusses findings. After discussing the design and implementation status of various workstreams and initiatives under Transformation, the report turns to their results, which are organized according to the objectives and outcomes outlined in the Theory of Change. In some case, some outcomes have been grouped together to avoid duplication and present findings with higher conciseness.

3. FINDINGS

3.1 TRANSFORMATION DESIGN, RELEVANCE & COHERENCE

This section discusses the extent to which the Transformation, in its overarching design and in its specific elements, has been relevant to meeting the organizational reform and change management objectives of being fit-for-purpose, as envisaged for the Organization at this juncture in its evolution. It includes discussion on the context, process and achievements with respect to the design of the Transformation. It broadly comports with evaluation criteria of design, relevance and coherence. The questions this section aims to address are:

1. What was the process by which the Transformation was designed?
2. What did stakeholders think about whether the right balance was struck between consultation and action, and between consultation and reliance on evidence and expertise?
3. How fit-for-purpose was the Transformation design in relation to the task at hand?

- ⇒ **Transformation represents an expansive and all-encompassing agenda for change. It has led to significant reorganization of headquarters, with structural realignment also initiated in the African, Eastern Mediterranean, European, South-East Asian and Western Pacific Regions**
- ⇒ **Transformation was designed with unprecedented involvement of staff. The design was largely appropriate; however as it was mostly seen as an exercise internal to the Secretariat, it missed out on some important opportunities such as meaningful engagement of Member States in the design of WHO Transformation.**

3.1.1 *The context for the Transformation design*

The case for a major overhaul of WHO was well established. Dr. Tedros, in his [vision statement](#), said:

“I envision a world in which everyone can live healthy, productive lives, regardless of who they are or where they live. I believe the global commitment to sustainable development – enshrined in the Sustainable Development Goals – offers a unique opportunity to address the social, economic and political determinants of health and to improve the health and well-being of people everywhere. Achieving this vision will require a strong, effective WHO that is able to meet emerging challenges and achieve the health objectives of the Sustainable Development Goals. We need a WHO – fit for the 21st century – that belongs to all, equally. We need a WHO that is efficiently managed, adequately resourced and results driven, with a strong focus on transparency, accountability and value for money.”

As stated in the *WHO Transformation Plan & Architecture*, “To effectively drive the global health agenda and to fulfil its mission, WHO must change.” Frequent reference was made during the course of this evaluation to the imperative of “moving the Organization into the 21st Century.” This imperative was characterized by the need for WHO to go from being an output-oriented normative agency that measures the number of guidelines produced to operating as a center of excellence and becoming a seamless, results-driven Organization that is able to measure impact on lives.

The Transformation represents a continuation of a series of reforms that have taken place since 2011. In many ways, WHO, like most entities of the UN system, has been in the process of reform for decades. The most recent evaluation of WHO Reform, undertaken before the Transformation began, covers the reforms of the period 2011-2017.¹¹ This evaluation noted the differences in approaches and outcomes between reform at WHO and other UN agencies (including UNICEF and ILO), and characterized WHO's approach as time-bound, top-down and Member States-led, and as such, the process was slow, and outcomes were not yet realized. The reforms, despite progress, were concluded to be incomplete. Three priority areas were identified: (1) Defining a clear business model for WHO's work; (2) Aligning WHO's operating model; and (3) Implementing requisites for success. Many recommendations were brought forward in the Transformation approach and desired results, including ensuring strong staff engagement from the outset and implementing a mandatory mobility policy. The normative function evaluation (2017)¹² made a number of recommendations on processes for developing normative products which were relevant and mainstreamed into the Transformation, particularly with regard to improving science and technology at all levels.

A Transformation was initiated in the African Region in 2015, which served as a precursor for reforms in other regions, as well as the Transformation at the global level. This regional transformation initiative had a mid-term evaluation in 2017, which also provided important inputs into the global WHO Transformation.¹³ That evaluation had concluded that the regional effort was generally successful. It reported observing reasonable progress towards achieving the aim of the Transformation to render the Regional Office more effective, timely and efficient in providing the best possible support to Member States. The report also noted that any reform required change not only in processes but also behaviors, which required a longer timeframe. Finally, that report also noted the need for: (i) strengthening communication, as an integral part of the Transformation, to cover both internal and external audiences with greater focus in the next phase, including better articulation of success stories and results at the country level; (ii) moving from a process focus to a stronger focus on delivery of results and better communication of the work of the Regional Office in this regard; and (iii) broadening the engagement of Member States and partners in the next phase.

The experience of the regional effort clearly helped identify critical elements for inclusion in the organization-wide Transformation such as a focus on making the Organization more effective and results-oriented through WCOs. The Transformation also built on results of previous assessments including the programme budget results performance report for 2018-2019¹⁴ and the MOPAN 2017-2018 Assessments.¹⁵ The MOPAN assessment, in fact, noted that the "reform efforts have provided a strong foundation for continued institutional development" and that "this programme of work integrates and builds on the previous reform agenda" (p.8).

The design of the Transformation was informed by these prior reforms. A report to the Executive Board in 2019 described the process in terms of five actions where "WHO's transformation process aims to reposition, reconfigure and capacitate the Organization within the broader purview of United Nations reform so that its normative and technical work is of an even higher quality, more sharply focused on the needs, demands and expected actions of Member States, and translates directly into results at country

¹¹ WHO (2017). [Leadership and management at WHO: Evaluation of WHO Reform \(2011-2017\), third stage](#), April 2017.

¹² WHO (2017). [Evaluation of WHO's Normative Function](#), July 2017.

¹³ WHO (2017). Report of the mid-term evaluation of the Transformation of the WHO Secretariat in the African Region, May 2017.

¹⁴ WHO (2020). [WHO Results Report - Programme Budget 2018-2019 Driving impact in every country](#) (A73/24 Rev.1), November 2020.

¹⁵ MOPAN (2019). [MOPAN 2017-18 Assessments](#), World Health Organization (WHO), April 2019.

level.”¹⁶ To do this, the Secretariat articulated a strategy to clarify and prioritize the role WHO plays in attaining the SDGs, thus seeking to clearly define the Organization’s goals and targets and drives the work of all staff members within this wider context. It also sought to redesign and harmonize across major offices the processes that underpin WHO’s core technical, business and external relations functions based on best practices and in support of the Organization’s strategy. In the new reform model, country outcomes were to be placed at the center of WHO’s work, by aligning the operating model across all three levels for impact at country level and by introducing so-called “agile” management practices that increase quality and responsiveness.

Acknowledging, as the mid-term evaluation of the Transformation in the African Region had noted, that reforms cannot be implemented by changes to the processes alone, the organization-wide Transformation also sought to promote a culture and environment that enable effective internal and external collaboration, ensure that work is aligned with strategic priorities, bring out the best in WHO staff members for fulfilling the Organization’s mission, and continue to attract and retain top talent.

Finally, taking a new approach to communications and resource mobilization, and bolstering partnerships, the agenda sought to better position WHO to shape global health decisions and generate adequate and sustainable financing. In the longer term, the Transformation also aims to move WHO from a cycle of repeated reform to a more financially sustainable, results-based organization focused on continuous learning and improvement.

The Transformation is also connected to a broader reform of the UN system at the country level, referring specifically to the Resident Coordinator System. As a report by the Director-General to the Executive Board stated:¹⁷

27. ... To realize the opportunities created by United Nations reform while delivering on its constitutional normative and coordinating mandate for international health, WHO must continue to engage fully and work through the governance, managerial and financial implications. WHO, through the Director-General, is engaged in the new United Nations Sustainable Development Group ...

28. Reform of the Resident Coordinator system should have a particularly positive impact on WHO’s work, through, among other benefits: high-level advocacy and an integrated approach to the health-related Sustainable Development Goals; higher-quality integrated planning and delivery of United Nations Country Team activities; and joint communications and resource mobilization. In this context, WHO has already doubled its cost-sharing contribution to the Resident Coordinator system, as required by United Nations reform. WHO supports increasing the collective accountability and transparency to host governments of the work of United Nations Country Teams. Within these teams, WHO is committed to strengthening their capacity and ensuring the coherence of their health activities, in addition to the coherence of their activities in other sectors that significantly influence health outcomes. ...

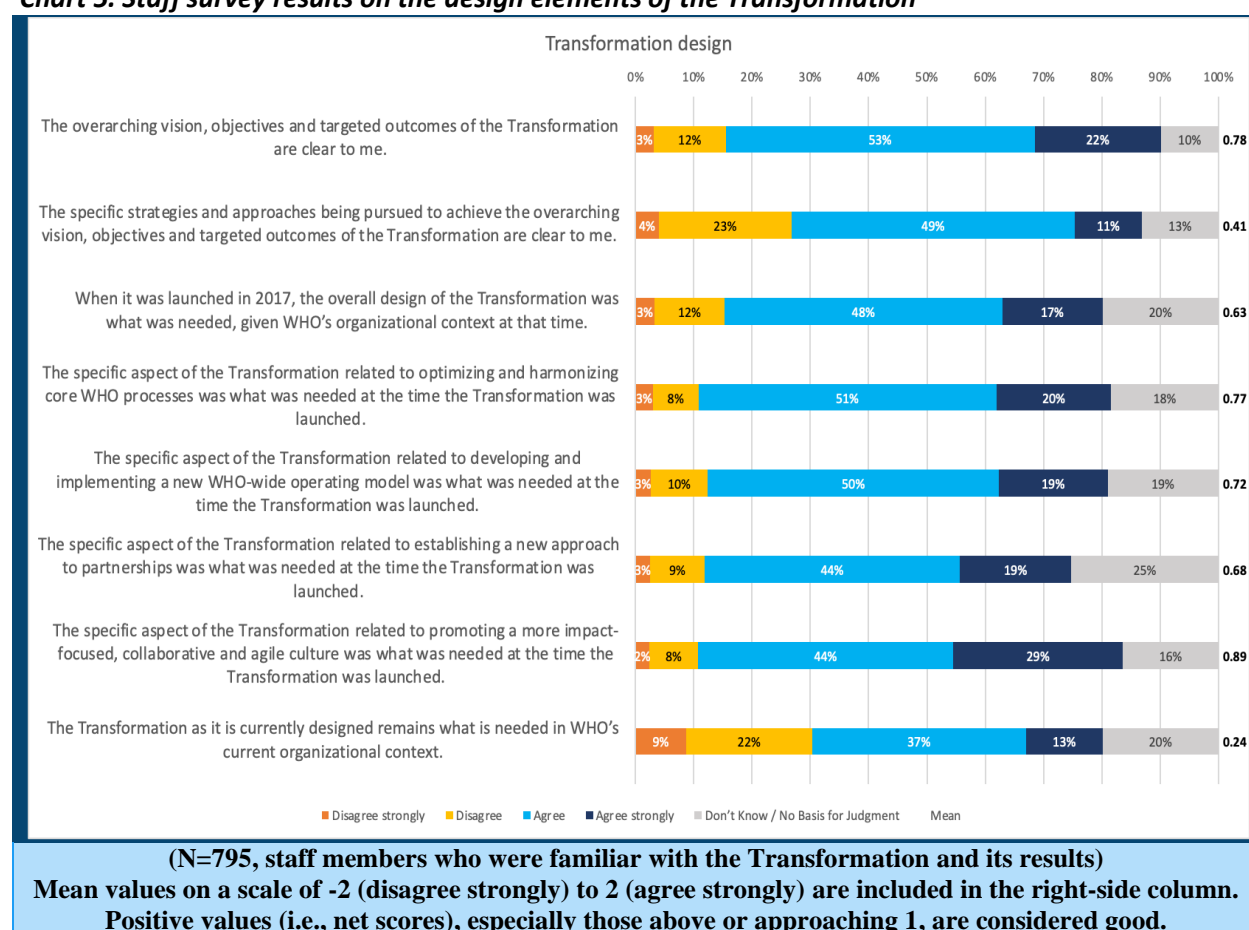
The staff survey elicited a positive response in terms of satisfaction with the planning and design of the Transformation, which showed that 59% of respondents agreed or strongly agreed it was well done and just 7% disagreed strongly. However, a subset of questions asking about different aspects of the design reveals varied reactions. Chart 5 below shows that the Transformation’s overall vision, objectives and targeted outcomes are well understood, although there is less clarity on the specific strategies and approaches used. As noted above, there is widespread support for the aims of the Transformation –

16 WHO (2018). [WHO reform processes, including the transformation agenda, and implementation of United Nations development system reform](#) (EB144/31), 28 December 2018.

¹⁷ Ibid.

promoting a more impact-focused, collaborative and agile culture – and for optimizing and harmonizing core processes. However, almost one-third (31%) of those who answered the question did not agree that the current Transformation design remains what is needed in WHO’s current organizational context (while another 20% selected ‘Do not Know/No Basis for Judgement (DK/NBFJ)’, which may suggest less connection with the Transformation during the time of the pandemic and general uncertainty about its significance post-pandemic. Overall, these results are similar to the views expressed in the Leadership and Management evaluation in 2017 on the previous reform,¹⁸ suggesting that buy-in into the design has not increased as the strategies were unrolled, which was matched by interviews highlighting a general sense of ‘reform fatigue’, where 21% of interviewees mentioned either concern for, or existence of, ‘fatigue’ and ‘tiredness’ related to the current Transformation as well as the various change initiatives under different nomenclatures which they have already gone through.

Chart 5. Staff survey results on the design elements of the Transformation

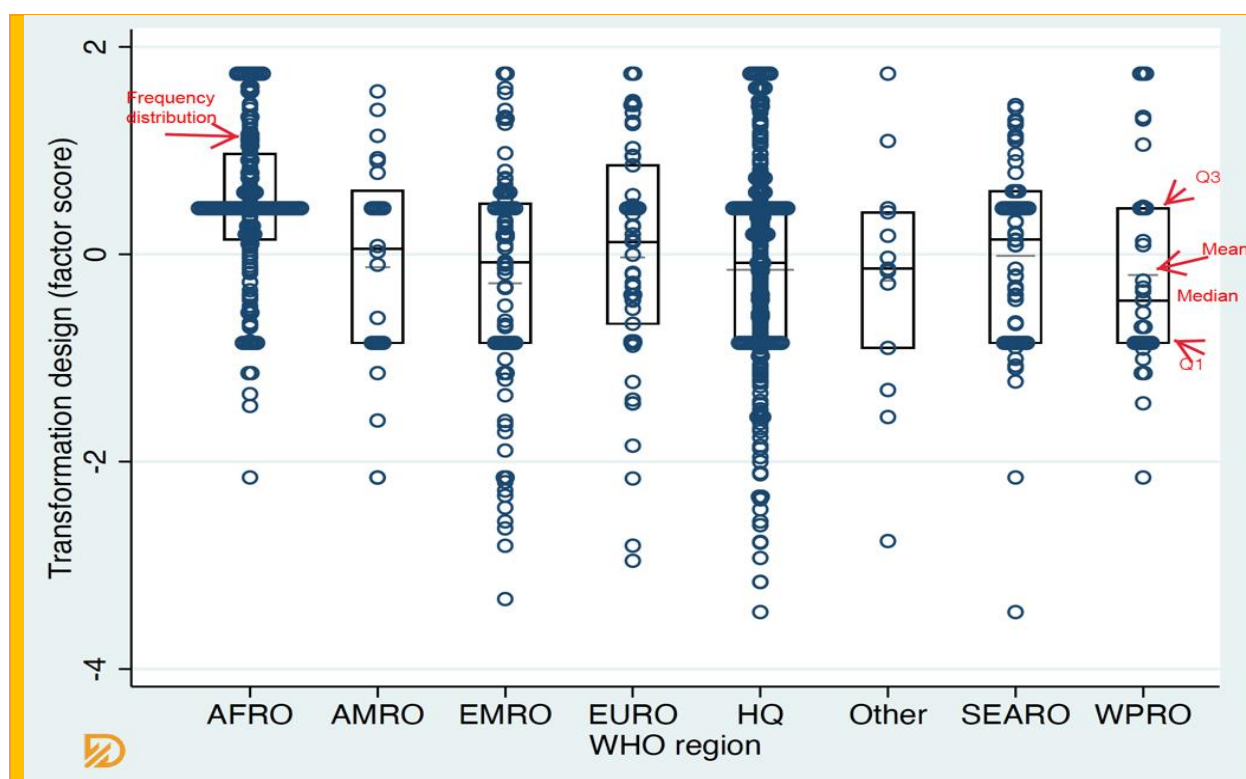


Staff assessment on the design of the Transformation differed by location. Chart 6 summarizes these variations from the staff survey in the form of a plot chart. In this chart, each vertical bar represents the distribution of staff feedback on the various aspects of the Transformation design from an "aerial" perspective: one can imagine looking down at the distribution from above, with a higher concentration of dark spots representing a higher concentration of staff scores stacked next to and on top of each other on the scale. The scale itself, meanwhile, is a "factor score" – that is, an index or summary measure

¹⁸ WHO (2017). [Leadership and management at WHO: Evaluation of WHO Reform \(2011-2017\), third stage](#), April 2017.

combining staff members' overall assessment of all of the elements of the Transformation design into a single underlying construct that captures their overall feedback on an element (in this case, Transformation design) by combining the information from a multitude of sub-questions.¹⁹ Within this context, 'boxes' generally higher up on the chart represent more positive overall assessments of the Transformation design; longer boxes represent a wider range of staff views, meanwhile, and fewer dark dots represent smaller numbers of staff members on a given point on the scale. Visual representations would be very similar to this if separate charts for each individual element of the design were presented separately, but this chart encapsulates the wide range of feedback on multiple dimensions into a brief summary overview of the feedback staff provided.^{20 21}

Chart 6. Staff on Transformation design as a whole: Regional variations



As shown in the strip plot in Chart 6, respondents from the African Region were not just the most positive in their ratings on the set of design questions, but also exhibited the least divergence in their perspective of Transformation. HQ staff and staff from the Western Pacific Region, in contrast, exhibited the least positivity driven by greater divergence of perspectives. Staff from the Region of the Americas and from

¹⁹ For more information on factor analysis, use this “Practical Introduction to Factor Analysis” <https://stats.idre.ucla.edu/spss/seminars/introduction-to-factor-analysis/a-practical-introduction-to-factor-analysis/>.

²⁰ Note that various elements from the above Chart were combined using principal component factor scores as analysis confirmed that these elements were dimensions of a common underlying factor (Transformation design). Factor 1 had an Eigen value of 4.58 and no other factor had an Eigen value higher than one. All questions had factor loadings higher than 0.5 (0.68 to 0.81). Thus, it provided strong evidence for the ability of a single factor to explain transformation design. Moreover, Cronbach's alpha was 0.89, thus providing further evidence for this to be a reliable scale for measuring transformation design at WHO.

²¹ Chart 6 depicts not just the average scores (mean and median) across staff, but also provides rich information to visualize the divergence of perspectives. It includes dispersion, interquartile range (25% and 75% of responses boundaries of the box) and cumulative frequency at various score levels. As the chart depicts net scores on a scale of -2 (strong disagreement) to +2 (strong agreement) across various design elements (depicted above in Chart 6), a positive net score approaching or above 1 is considered good.

the Eastern Mediterranean, European and South-East Asian Regions were somewhere in the middle (and neutral). However, the evaluation did not discern any significant difference in perspectives on the basis of different staff groups – Professional staff (P-staff), General Service staff (GS-staff), National Professional Officers (NPOs), and others.²²

The interviews and qualitative comments on the survey suggest that the African Region’s earlier adoption of its Transformation and more established processes may have led to more favorable viewpoints. Eighty-five (85%) of interviewees from that Region discussed in interviews being more confident in their role because of the clarity provided by workplans aligned with the triple billion goals and the organizational cultural shifts that enabled them to be more effective, and they clearly welcomed more results-driven reporting processes.

Overall, while the Transformation carried forward the impetus for change towards country-level relevance and impact within the broader UN-system, and responded to lessons learned from previous reform cycles, it fell at a time of pre-existing ‘reform fatigue’. Stakeholders also felt that COVID-19 has been the focus in 2020 and to date this year, diverting attention from certain areas of Transformation which do not currently align with the pandemic response priorities.

3.1.2 The process for Transformation design

The development of the Transformation involved extensive consultation with staff at various levels of the Organization, the experiences of regional transformation processes, recommendations from evaluations of previous reforms, as well as external expertise and benchmarking which brought a more ‘science-based’ approach to change management through the application of ‘deliverology’. This led to the *WHO Transformation Plan & Architecture*, published in February 2018, which presented the roadmap for achieving GPW 13. Features of the design evolved significantly as the change rolled out, demonstrating that the process was flexible and feedback loops were incorporated. It was mostly an internally-driven approach, involving many components that each spurred a range of initiatives and subsequent activities, although involvement of consulting companies helped bring in elements of externally-driven approaches. This section discusses core elements of the design process raised during the evaluation that seem to be the most significant for the progress made as well as aspects that were perceived as missing.

Staff consultation was the starting point and has been a cornerstone of the Transformation process. As noted in the report to the 144th session of the Executive Board in 2019,^{23 24} shortly after taking office the Director-General made an open request to all staff for ideas that could inform WHO’s organizational change and hundreds of suggestions were received. These were consolidated and prioritized by the Internal Working Group on Initiatives for Change who then also proposed a set of enabling initiatives²⁵ that became the foundation of the Transformation plan. Data collected from staff surveys (including culture and pulse surveys) provided a baseline for the state of organizational culture.

²² Although professional staff at HQ were slightly more negative, the difference was not statistically significant.

²³ WHO (2018). [WHO reform processes, including the transformation agenda, and implementation of United Nations development system reform](#) (EB144/31), 28 December 2018, paras. 6-7.

²⁴ In particular, the Report of External Auditor, Evaluation Report of Stage 1 of Reform Proposals of WHO, March 2012; and WHO (2017). [Leadership and Management at WHO: Evaluation of WHO Reform \(2011-2017\), third stage](#), April 2017.

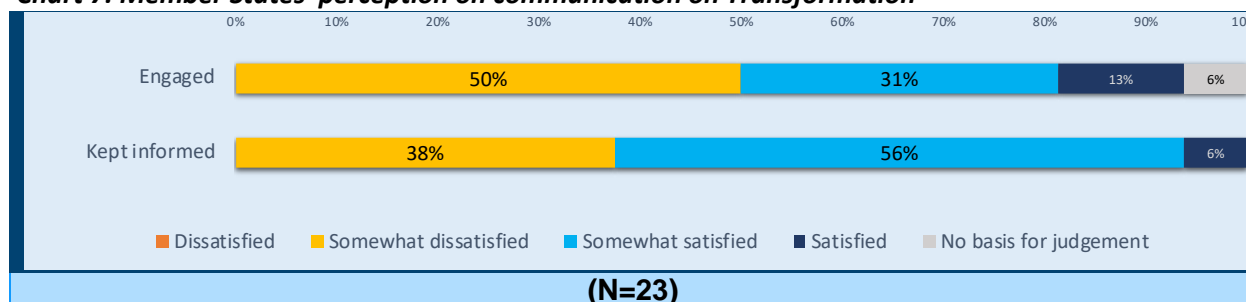
²⁵ The enabling initiatives included E1: Strategic positioning of WHO’s work at country level and strengthening of country offices; E2. Workforce of Excellence; E3. Increasing WHO’s visibility, brand recognition and relevance; E4. Resource mobilization, fundraising; E5. Nexus for Health 2030 Digital Transformation & Data Revolution; E6. From silos to matrix: UHC in WHO; E7. Knowledge Management; E8. Addressing Administrative and management processes. [First Report of the Working Group on Initiatives for Change, not dated].

According to the most recent progress report on Transformation,²⁶ staff engagement has been greater than in any other reform. Of a workforce of approximately 8000 worldwide, staff participation numbers include: 800+ in design and redesign of core processes; ~200 in global Task Forces; ~5600 in the baseline survey; and 2700 in the 3-day Values Jam. Notably, the consultation opportunity most frequently mentioned during the evaluation was the ‘open-door’ policy modelled by the DG, which opened the DG’s door and ear to staff’s candid feedback on ways to improve the Organization.²⁷

Consensus-based decision-making processes were promoted to the extent feasible. Transformation staff noted they faced the task of getting consensus or, if not possible, presenting ideas and options that had emerged from different processes to the DG for him to decide upon. This took time but was a core principle.

Member States were less involved in the Transformation design than during previous reforms. Over one hundred (112) consultations were reportedly held with Member States on issues such as budgets and results measurement, primarily linked to their more extensive engagement in the development of the GPW 13, but consultation on decisions such as human resources and on norms and standards were not common. As a result, while Member States saw the Transformation design and approach as largely positive, they also felt inadequately consulted on many of its facets. In their assessment the positive aspects of the Transformation included the development of a new organizational structure in HQ and a new emphasis towards better processes, including delegation of authority. On the flip side, they believe that WHO needed to do a better job in developing and communicating in terms of specific targets, objectives and accomplishments of Transformation. This is also reflected in the Member States’ questionnaire, where a significant proportion of respondents felt that they had not been engaged adequately in the Transformation process (Chart 7), as well as in FGDs in which 46 Member States participated.

Chart 7. Member States' perception on communication on Transformation



Overall, by viewing the Transformation as a technical and internal matter of the Organization, WHO missed on an important opportunity to engage with Member States not only on what type of Organization they wanted, but also on reshaping itself for the larger country-level impacts (which is one of the stated goals of the Transformation). Further, it also meant that the Transformation also did not address governance issues that have an important bearing on the performance of WHO.

²⁶ WHO (2020). [The WHO Transformation: 2020 progress report](#).

²⁷ Although, a substantial number (17 KIIs and 4 FGDs) of HQ interviewees revealed that the open-door policy has not trickled down to other levels.

External expertise was drawn upon for designing several key pieces of the Transformation, such as business process redesigns, from management consulting firms including McKinsey, Price Waterhouse Cooper (PWC), Boston Consulting Group (BCG) and SEEK. Of these, McKinsey was the most substantially involved through the design of the operational model, 'end-to-end process redesigns', and introduced the Deliverology approach, which defined the structure for reflecting and drawing on previous lessons from reforms.²⁸ This approach was pioneered in the United Kingdom and subsequently used in many government and other public-sector reform efforts but had not been used in other UN-agency reform processes. It helped to inform much of the design and rollout of the Transformation. Other firms had more targeted scopes of work, with BCG looking specifically at norms and standards and internal communication towards the objective of adapting more agile ways of working, SEEK focused on external relations and resource mobilization, and PWC conducting an evaluation of previous reform efforts.

Lessons from regional experiences, strategic evaluations and country office review processes also played a role in informing the design of the Transformation. As mentioned, much was learned from the African Region's earlier and ongoing experiences of transformation with initiatives such as the Region's change agent networks and Pathways to Leadership for Transformation being adopted Organization-wide (24% of all interviews noted the African Region's contributions to the Transformation design). Other regional initiatives and processes were also drawn from, including the virtual campus for knowledge management in the Region of the Americas, digital workflow processes in the South-East Asian Region and Programme Planning, Monitoring and Evaluation (PME) systems in the Eastern Mediterranean Region (10% of interviews noted the early start on Transformation objectives in this Region as well). In addition to the evaluations of the previous reform and the mid-term evaluation of transformation in the African Region, key evaluations included that of WHO's Presence in countries (2016²⁹). The results of country office reviews have fed into both the design and ongoing implementation of the Agenda to inform the work on increasing country-level impact. As of February 2020, Regional office-led country reviews had been carried out in more than 80 countries in four WHO regions; In-depth functional reviews had been implemented in 47 countries in the African Region and in 18 countries in the Eastern Mediterranean Region; programmatic and administrative reviews were completed in all 11 countries of the South-East Asian Region; and management and administrative reviews were carried out in 6 countries in the European Region.³⁰

However, concerns were also expressed about internal knowledge not being sufficiently valued, and there being a tendency to 'start from a clean slate' rather than fine tuning, or improving upon, existing processes, counter to the intent of the deliverology approach. From staff assessments, this was represented by the hiring of external consultants in the design phase as well as a lack of clarity in communication on exactly how previous evaluations were consulted in order to derive the priorities of the Transformation.

Assessments and benchmarking against public- and private-sector entities were prominent in the design phase and were used in all 13 process redesigns to help ensure the incorporation of 'best-in-class' practices. Examples of industry tools and expertise include use of the McKinsey's Process Assessment VS Best Practice Scorecard and Organizational Health Index. The latter was the basis for the culture

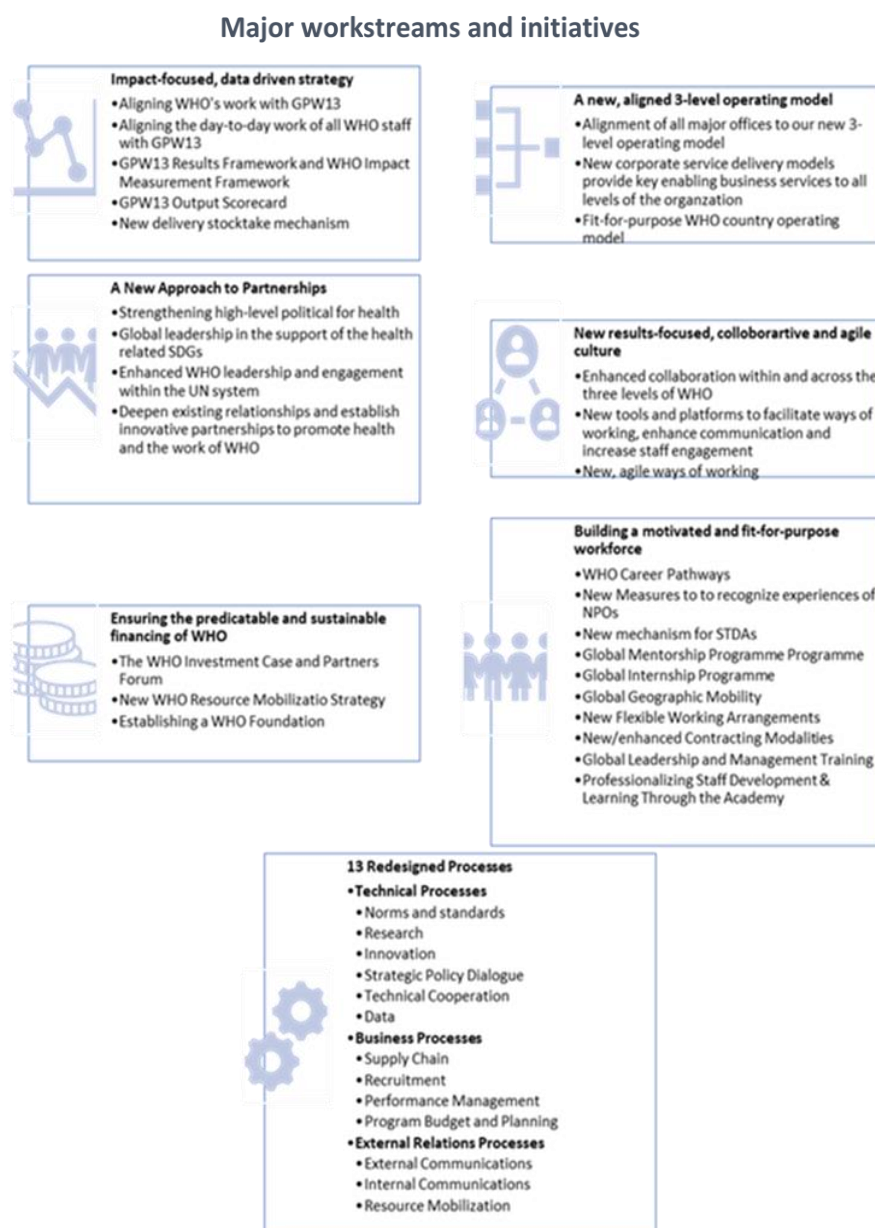
²⁸ The key components of Deliverology include evaluating past experience in setting goals and implementing new strategies and reflecting on non-achievement, the formation of a small delivery unit that is situated outside the organization's line-management hierarchy, gathering performance data to set targets and trajectories, and using routine reviews to ensure a focus on performance which includes 'stock takes' and 'delivery reports'. [<https://www.mckinsey.com/industries/public-and-social-sector/our-insights/deliverology-from-idea-to-implementation>. Accessed January 20, 2021.].

²⁹ WHO (2016). *Evaluation of WHO's Presence in Countries*, 2016.

³⁰ WHO (2021). *WHO transformation – Transforming for enhanced country impact* (EB148/32), 4 January 2021.

component of WHO's 2017 staff survey and enabled the results to be benchmarked against other public sector organizations' results. The 2017-2018 MOPAN Assessment Report³¹ on WHO provided benchmarks for organizational change across several strategic management, leadership systems and reforms through 2018. Use of comparators continues to be standard practice during the Transformation implementation phase. A recent example is the World's Healthiest Organization initiative which aims to promote staff health and well-being. The initiative started out by benchmarking WHO on a range of dimensions capturing healthy practices against other UN, social sector and private sector entities.

Chart 8. Seven workstreams of the WHO Transformation and their corresponding initiatives



³¹ MOPAN (2019). MOPAN 2017-18 Assessments, World Health Organization (WHO), April 2019.

Leadership by Global Policy Group (GPG)³³ set the course of the Transformation effort. It aims to meet either face-to-face or by videoconference every month. The involvement of the GPG was considered critical by many interviewees, bringing together parts of the Organization which have historically operated quite independently, and providing a mechanism for increased exchange across the WCOs, ROs and HQ. The DDG/DPM Working Group of senior directors from each of these offices gives input and recommends options to the GPG, such as consultation on the culture survey findings, further ensuring whole-of-organization buy-in and participation. Eleven percent (11%) of interviewees corroborated the importance of the GPG in ensuring internal coherence, although some interviewees noted that the lack of transparency surrounding GPG discussions might signal a reduced role of some ADGs/Directors while placing greater decision-making authority for policymaking in hands of Regional Directors (RDs).

The Global Transformation Team carried out the directions of the GPG. This included extensive consultation and research during the preliminary design phase, including 14 visits to all regional offices and 6 additional WCOs in 2017–2018, as well as ongoing remote meetings. Trip reports show the breadth of work carried out with the regions to support GPG deliberations. For the most part, interviewees appreciated the Transformation Team for the manner with which it led the Transformation, although some interviewees expressed concerns about a lack of transparency in some processes (such as in restructuring HQ and closed discussions with the GPG without sharing of meeting minutes with other senior leaders and existing networks, such as the Global Staff Management Council) and the length of involvement and budget spent on the external consultants without clear communication on their role.

Four-pronged Approach

The lessons and findings from initial consultations and reviews were used as the basis for a holistic, four-pronged approach:³²

- ⇒ **Strategy** – a new strategy, the GPW 13, was developed to align the work of the entire Organization with the targets of the health-related SDGs.
- ⇒ **Processes** - WHO's core technical, external relations and business processes were examined and prioritized for redesign, beginning with the programme budget process, so that the Organization could work more effectively. The workstreams and initiatives to carry out the redesign are shown in Chart 8.
- ⇒ **Operating Model** - the overall operating model, which was designed to deliver the GPW 12 was analyzed and options were formulated for a redesigned model across the three levels of the Organization to ensure delivery of the new strategy and that the core processes are applied consistently.
- ⇒ **Underlying Culture** – assessments of the capacity of and enabling environment for WHO staff members to do their work led to core actions being identified at the corporate, major office and team levels to change the mindsets and behaviors of all staff, including senior management, so that the new operating model would function well.

The transformation process has also included an ongoing rethinking of WHO's approach to external engagements in order to effectively communicate, finance and implement the new strategy.

³²WHO (2018). [WHO reform processes, including the transformation agenda, and implementation of United Nations development system reform](#) (EB144/31), 28 December 2018.

³³ GPG membership includes the Director-General, Deputy Directors-General, Regional Directors and Chef de Cabinet.

The Global Transformation Team brought together working groups at all levels, horizontally and vertically, supported by staff in each RO. It also initially managed all Transformation processes, including the set up and running/co-running of the 13 core process redesigns for human resources, communications, supply chain, and normative work, before handing those over to business owners.

WHO's first Global Management Meeting, held in Nairobi at the end of 2018, brought together senior management from all offices. In addition to reviewing progress of the Transformation, it was an important opportunity for participants to agree on new ways of working to deliver GPW 13 and reach agreement on moving forward with the new WHO Values Charter, the new operating model, and redesigned processes, among other issues such as a discussion on 'agility' and how it can be applied to enhance collaboration and responsiveness. The meeting was also notable for including a session with the UN Deputy Secretary-General to help ensure WHO's full alignment with and engagement in UN reform.

Quick Wins was a strategy employed to show more immediate results of the Transformation as well as to promote ownership of the Transformation process. Thirteen actions were targeted to be implemented, several in the first six months. Some of these had been in process for some time and were included to expediate their operationalization and demonstrate that change was happening. Quick wins largely focused on restructuring, including reviewing the scope and location of WHO's work, distributing skills of its workforce across the three levels, and updating reporting lines and internal governance. Quick wins were widely commented on within interviews across WCOs, ROs, and HQ (44% of interviews), and staff assessment on the success of quick wins was largely mixed, with 79% of those commenting noting slow progress on certain action items (such as the Delegation of Authority giving greater accountability to WHO Representatives (WRs)), lack of commitment to implementing such changes (e.g. career pathways, staff mobility and the broader distribution of staff across the three levels) or re-instituting the top-heavy nature of the organizational structure, counter to the Transformation's country impact focus.

Internal communication processes have also been a key element of the design, important for keeping staff informed of the plethora of initiatives that constitute the Transformation and their progress. Internal communication includes Town Halls, monthly updates to all staff from the DG and a dedicated Intranet site containing relevant information. The Transformation journey is well depicted in a graphic timeline that shows key events and milestones of the process; it appears on the intranet site, is periodically updated and is frequently featured in reporting. Although much of the work just described primarily reaches HQ staff, there are also global communication initiatives. Of these, consistent messaging by the DG on the need for the Transformation was highlighted in interviews at all three levels as being particularly helpful in moving the agenda forward.

Ongoing staff engagement, including through a range of working groups, has drawn members from all three levels of the Organization to develop the content in each major area of Transformation. Major initiatives frequently cited during the evaluation involving multi-level staff collaboration were the design and finalization of the GPW 13 Results Framework and the development of administrative/finance policies. There have been purposeful attempts to engage WRs to play a central role in these discussions and processes, which was an explicit action item within the Transformation 'quick wins'.

Feedback systems are shown to have played a prominent role throughout the Transformation's design and roll out, and during ongoing implementation. Over 300 staff were selected, based on results of a global survey, to be Change Supporters and are part of a global network who engage with and provide feedback on Transformation processes. Pain point exercises and staff surveys including Pulse Checks carried out in different phases of the Transformation enabled staff to share opinions on what is and is not

working in the Transformation and to contribute ideas for improvement. Other examples of such iterative practices include the piloting of a range of exercises, most recently the output scorecard, that involves all three levels in design and testing, and now redesign. Existing networks, such as the Staff Association, also sit on taskforces for the various exercises, including the mobility simulation and staff health insurance discussions.

Although a set of clear strategic objectives were developed, the Transformation architecture did not include a robust theory of change or logic model that looked at linkages between components and clearly articulated a measurable end state, focusing instead on changing processes. As a result, there has been some uncertainty about whether and when the Transformation will end, what the markers will be, and the metrics to measure success. Although documents show that there were presentations on what Transformation success looks like and how it will be measured, there was little understanding or awareness of this found amongst stakeholders interviewed.

Chart 9. Staff survey results on communication regarding the Transformation

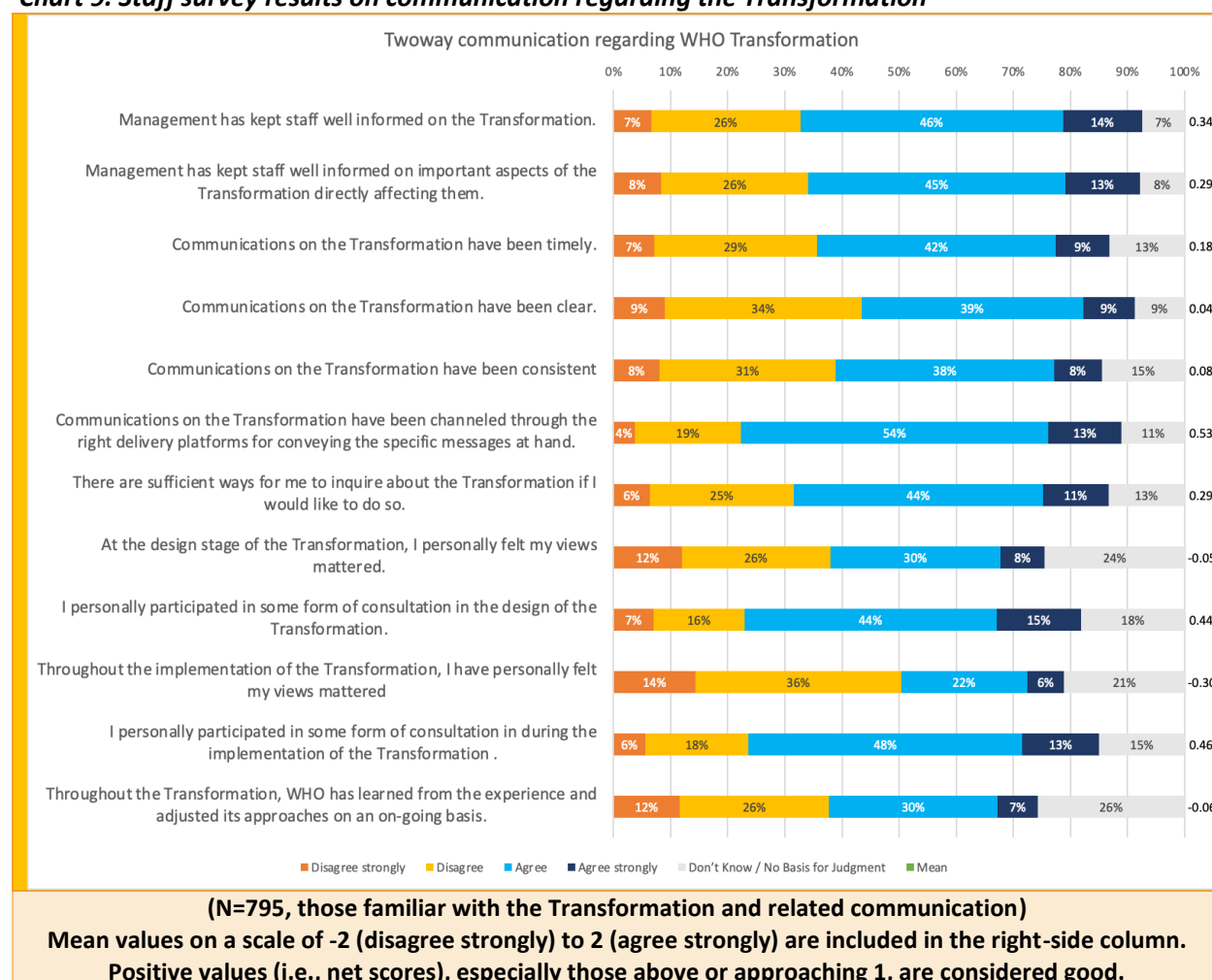


Chart 9 addresses staff perspectives on consultation and communication. The majority of survey respondents, who were familiar with the Transformation, felt that management kept them well informed of the Transformation (60%), and that communications had been channeled through the right delivery

platform (67%). There were varying perspectives on timeliness, clarity and consistency of communication. In respect to participation in some form of consultation – 59% said they participated at the design stage and 61% at the implementation stage. However, despite the extensive consultation processes, a lower proportion of staff considered that their viewpoints were taken into account. Just 38% felt their view mattered at the design stage, with equal proportions disagreeing with this statement and another 24% not expressing an opinion on this matter. At the implementation phase, fewer felt their views mattered (28%), with just 6% strongly agreeing. Fourteen percent strongly disagreed. The interview data provide an explanation. Although the many opportunities for participation have been mostly well appreciated, interviews also brought out some concerns about consultation processes that were too rushed, not well explained, or not structured in a way that enabled dialogue and input.

Similar trends emerged in the interviews. Of the 41% of interviews commenting on internal communication practices, there was equal distribution of critique, neutrality and positivity in staff assessments of internal communication practices. Positive feedback was provided on the various Transformation Working Groups and networks, as well as the focus on more remote/virtual means of communication, such virtual townhalls and DG newsletters, all initiated prior to COVID-19 though carried through and improved throughout the pandemic. Critiques of internal communication focused on the centralization of internal communication processes at HQ, the open-door policy obstructing management lines, and the quality of staff consultation on the Transformation, and weighing how these changes have decreased efficiency in communications with WCOs or decision-making processes.

For example, staff assessments presented some misunderstanding on pathways for communication, particularly at the country-level, with some WCOs welcoming the centralization of communication at HQ, defining clear contact persons for WCOs, while others saw that centralization removed ROs from their helpful role as liaisons to WCOs, filtering information from HQ to ensure what reaches them is better contextualized and explained. WCOs, in particular, reported receiving too many requests from HQ regarding the Transformation without clear explanations on the intention or desired outcome of the meeting or information request. For example, one country-level staff highlighted the extensive number of people from HQ involved in implementing Transformation-related processes (outside of the Transformation Team), who had not been adequately introduced, and who frequently contact WCOs with requests and new templates to comment on or complete. This is further commented on within the findings on outcomes.

Overall, the communication has been good on some aspects, but uncoordinated, unclear and one-way in other respects. It has also been distracted by other tasks perceived as higher priority, especially with the COVID-19 response at hand.

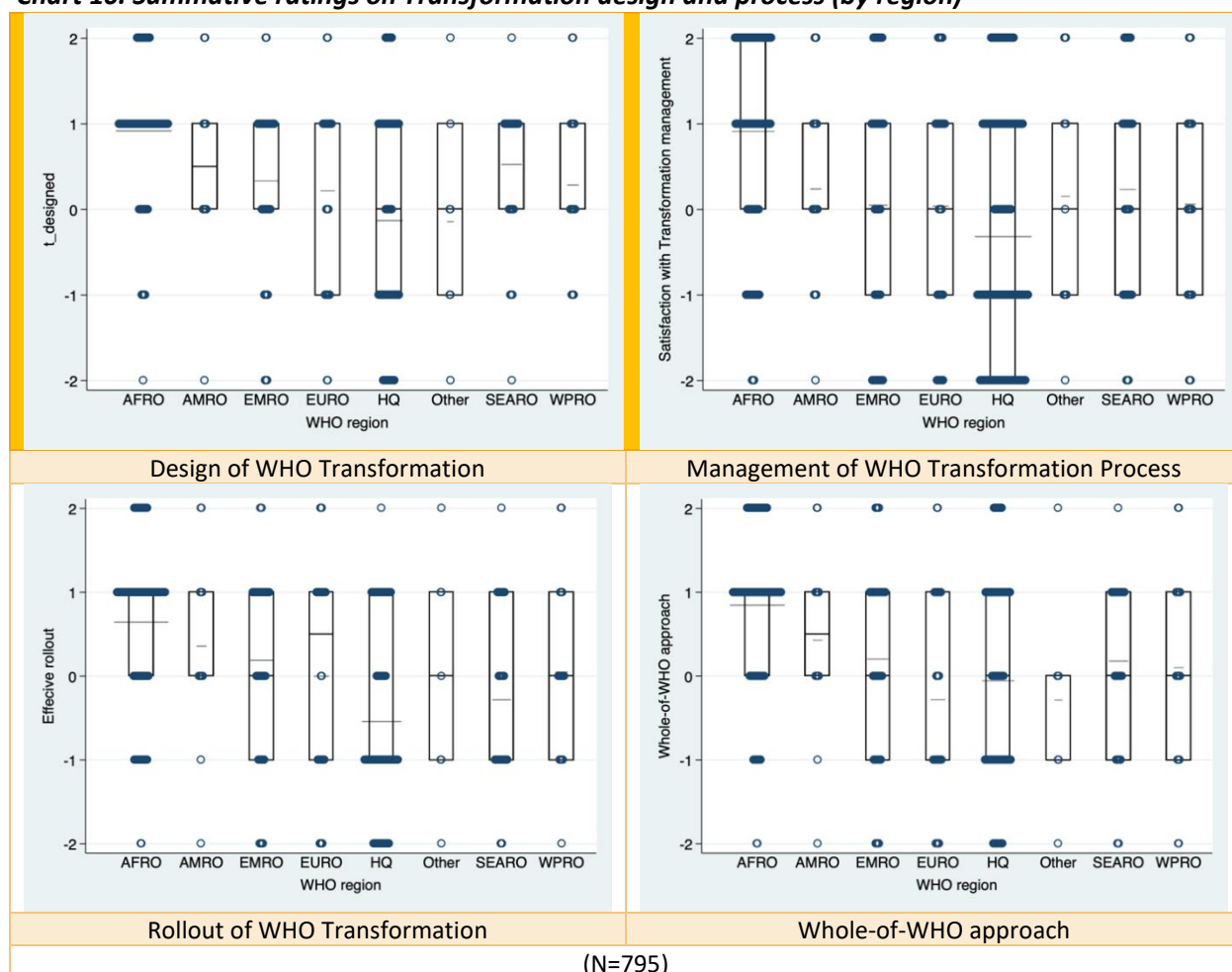
3.1.3 Transformation design and achieving desired changes

The Transformation has clearly been ambitious in scope and size. As the DG noted in his May 2020 speech, although advice had been given to redesign no more than two to three major processes at once, his vision for change was to be faster and more ambitious. Eleven processes were initially identified for major redesign, namely: programme budget and planning, resource mobilization, external and internal communications, recruitment, supply chain, performance management, norms and standards, research, data and technical cooperation. Innovation and strategic policy dialogue were subsequently added to the list to help ensure greater country relevance. The result was an exceedingly complex change process,

particularly for an organization with WHO's size, structure and mandate. As to be expected, reactions to the elements of the change are mixed. Many of stakeholders interviewed felt that the ambition of the Transformation was precisely what was needed, although some questioned the cost. A common assessment was that although the goal of the Transformation was for WHO to become country-focused, a new operating model at HQ was first required to achieve country-level impact and the achievement of GPW 13.

The level of ambition in these change processes appears to have been needed for the Organization to continue to be relevant and sustainable, and to be able to deliver the GPW 13. It covered critical pieces of internal change processes that needed to be looked at, at that point in time, other than Member State engagement as noted above. However, the varying levels of staff satisfaction across offices suggests that various aspects of the management of the Transformation process need to be looked at, and this is taken up in the next chapter. Priority issues include the need to communicate the continued relevance of the Transformation and its gains as the Organization shifts back from the COVID-19 response, and the need to ensure that consultation processes are well designed and delivered so that the process is felt to be genuine. Questions about whether the Transformation adequately addressed the role of regional offices were also raised.

Chart 10. Summative ratings on Transformation design and process (by region)



The strip plots (Chart 10) depict ratings from the staff survey on Transformation design and process. It presents raw data on various questions on a scale of -2 (strong dissatisfaction) to +2 (strong satisfaction). As seen across all plots, respondents from the African Region once again exhibit the highest positivity. HQ staff once again exhibit the highest divergence, especially with regard to the question on the management of transformation process.

Overall, based on the evidence available from multiple sources, it is clear that the Transformation design was a large endeavor that has been rolled out on the basis of extensive consultation. Despite the varying perspectives, there is a general

consensus that it was a well managed process. However, it was constrained by time and lack of familiarity with externally-sourced management principles amongst staff, which rushed some consultations and left out others, and limited the buy-in needed for such an ambitious Agenda.

Milestones of the Design Phase

- 1 – Adoption of the 13th General Programme of Work (May 2018)
- 2 – WHO-wide Harmonization of 13 Core Processes (December 2018)
- 3 – WHO-wide Operating Model (March 2019)
- 4 – First WHO Partners Forum (April 2019)
- 5 – Launch of WHO Values Charter (May 2019)

3.2 IMPLEMENTATION STATUS AND PROGRESS

This section discusses the status and progress on implementation of WHO Transformation, focusing on the extent to which WHO leveraged its human, financial, technical and technological resources to maximize the Transformation's success. It broadly comports with the efficiency, including timeliness and cost-effectiveness, criteria. The evaluation questions it aims to answer are:

1. What is the status of the Transformation? To what extent is it on or off track?
2. What outputs and activities have been particularly timely, relevant and well received?
3. What are the factors that help explain successes, shortfalls and delays?

⇒ **Around half of the 40 initiatives have been implemented so far; however, given the scope of the Agenda and the unexpected focus on pandemic response, progress has been substantial.**

⇒ **Implementation has been affected by COVID-19 but gains were still made in past year. WHO appears to be well positioned to deliver on most of the remaining initiatives in 2021.**

WHO's work on the Transformation is organized under seven workstreams, each of which has multiple initiatives and within them, sets of activities. The level of achievement across the seven workstreams has been mixed, with some initiatives being much more complex to roll out because they have strong linkages and dependencies with other workstreams, most notably redesign of 13 core processes. COVID-19 and the need to shift resources to the pandemic response has had a major impact on implementation progress and has, in some cases, accelerated processes, though in most cases caused delays.

The formal announcement of the shift from the Design to the Alignment & Initiation Phase was made in March 2019. In January 2020 the 4th Phase of Implementation & Continuous Improvement began, just less than a year behind what was envisioned in the 2018 Transformation Plan & Architecture document³⁴ where it was proposed that all changes would be consolidated by mid-2019. Now, two years later, as of the first quarter of 2021, implementation was characterized as being about two-thirds complete by several business owners and other HQ staff, with many field staff perceiving that less progress has been made. At this point reporting shows that approximately half of the initiatives are in full implementation, a quarter are in partial implementation, and the remaining are in initial stages of implementation.

Tracking all of these initiatives has been a complex and ongoing process, but has been carried out systematically by the Transformation Team using a tracking tool. During the design stage, progress was recorded through detailed Global Transformation Team workplan tracking sheets. These were also useful tools for the transfer of responsibility for initiatives to the line management/business owners during the transition to the implementation phase, though there was concern within 14% of interviews that this tool alone was insufficient to ensure business owner accountability for timely, effective and sustained implementation of initiatives. Currently, the Transformation Office maintains a consolidated tracking sheet to provide a high-level overview of what is happening across the complex and comprehensive agenda, and to promote a consistent approach to measuring and reporting output-level progress. Tracking and monitoring is also being done to varying degrees at the regional level, with a detailed approach being followed in the African Region.

³⁴WHO (2018). [WHO Transformation Plan & Architecture](#), 16 February 2018.

Chart 11. Number and stage of various initiatives under different workstreams

Number and stage of various initiatives under different workstreams



The most recent report - *The WHO Transformation: 2020 progress report* - presents an overall picture of the scale and breadth of achievement as of the third quarter of the year. In addition to highlighting milestones and other achievements, charts with icons visually depict the level of progress in each workstream initiative. Reporting relied on self-assessment with business owners assigning a rating of 'fully

implemented’, ‘partially implemented’, or ‘initiated’ for their respective work areas. There was not a clear procedure for assigning progress levels, which was a limitation in respect to data reliability and validity, and may account for some interviewees saying they were skeptical about claims made.

This following discussion highlights the output-level achievements presented in the 2020 Progress Report along with data gathered during the evaluation. It is not intended as an audit of the progress of each activity,³⁵ nor does it capture the full range of work that has been part of the Agenda. Chart 11 shows the status of workstreams as reported in the 2020 Progress report and includes a judgement by the evaluators (orange icons) on subsequent progress identified through interviews and monitoring documents. Two workstreams appear to be well on-track, four have seen substantial progress in the last quarter, and one has initiatives that are still in the development phase. Additional information on milestones by workstream can be found in Annex III.

3.2.1 *Progress by Workstream*

Establishing and operationalizing an impact-focused, data-driven strategy.



Substantial Progress Made

This workstream focuses on the alignment of the day-to-day work with WHO’s mission and strategy, and being able to effectively monitor and manage results. It includes foundational pieces of the Transformation – the rollout of the new Programme Budget Planning processes, workplan alignment with GPW 13 and the GPW 13 Results Framework – which are all completed. Changes introduced to the individual performance objective planning process in 2020 made it mandatory for each objective to be linked to a GPW 13 output. Accordingly, in 2020 and in 2021 the objectives of every staff member have been linked triple billion to GPW 13 outputs. The two remaining initiatives, which are key to measuring progress towards the goals, include the Delivery Stocktakes which are continuing to be rolled out to track impact across programme areas (by December 2020 global stocktakes had been completed for each of the billion targets), and the Output Scorecard. The Output Scorecard and guidance were piloted and were rolled out to all offices in Q1 2021 as part of the Mid-term Review of the Programme Budget 2020-2021, with some interviewees indicating that the process was “painful” and was not capturing the results that they hoped it would. Others highlighted how the focus on results, and the associated breaking down of silos in budget and planning towards the delivery of country-level impact, has helped to increase communication and coordination internally; this was noted by WCO, RO and HQ staff in interviews. There is widespread recognition of their importance and of the immense amount of work that has gone into this development process, and most were hopeful of these processes and tools being further refined.

Establishing “best-in-class” technical, external relations and business processes



Substantial Progress Made

The objective of this workstream is to harmonize key processes across all WHO major offices. During the design phase of the Transformation, 13 different processes were identified as needing to be designed or redesigned. The 13 business processes are categorized by: (1) technical (norms and standards, research,

³⁵ A regular monitoring and problem-solving approach of the Senior Management team and Transformation Initiative Business owners was agreed at the start of 2021 and reviewed by the HQ ExM on 9 March with a decision to institute up to weekly meetings as needed from 18 March. Additional workstream progress is likely to emerge as this monitoring process is implemented.

innovation, technical cooperation, data, strategic policy dialogue); (2) external relations (resource mobilization, external communications, internal communications); and (3) business processes (programme budget and planning, recruitment, performance management, supply chain). Staff survey results showed just under half of respondents being satisfied and one third being dissatisfied with how this workstream has evolved.

Early progress was made in implementing the three External Relations processes. As mentioned earlier, there were concerns on whether centralization of internal communications was what was needed, and whether it will result in its intended effects of optimization and harmonization of core process and increased agility. In the external communication redesigned process, WHO external communications were to be driven by a single, corporate, WHO-wide annual plan that is jointly developed by the 7 major offices, emphasizes country content and is aligned with modern digital communications. Staff assessments were quite positive on the relevance and timeliness of this process with the onset of COVID-19, and how it has helped to expand the number of platforms such as social media, to increase visibility and push forward a consistent corporate image of WHO. Counter to what was felt by WHO staff, the timing for the centralization of communications has had a negative effect on processes for the WHO Health Emergencies (WHE) Programme; without clear parameters yet set, it was initially seen to slow down the WHE Programme's ability to respond in crisis (through press conferences, for example). In this case a solution was found, and is one of several instances reflective of increasing agility of WHO's management practices.

Of the six technical processes, two were flagged as being in the start-up phase in the Progress Report. One was Innovation, which although noted as being under-resourced, carried out activities as part of the COVID-19 response and is launching the second LEAD challenge. Norms and Standards, instituted under the new Chief Scientist, was intended to streamline and reduce duplication in guidelines and policies, and has been spotlighted in the past year, being responsible for clearing COVID-19 related publications. At HQ level, this was acknowledged as an accomplishment in interviews, though CO and RO interviews still desired the process to be improved to increase relevance to varying country contexts.

The COVID-19 pandemic has brought to the fore the need for timely, reliable and actionable data, highlighting the criticality of efficient data processes. Substantial progress has been made in this area since the last progress report – the Triple Billion Dashboard going live with data being regularly updated, including the additional scenario tools that enable countries to examine alternate scenarios in making progress towards the triple billion targets, and the recent launch in January 2021 of the SCORE global report on health systems data. The initial minimal viable product of the World Health Data Hub is now ready with the country portal having been used in several country consultations, the data lake with the COVID-19 mortality and surveillance data, and the datadot visualization and external facing website. The full working version of the end-to-end corporate solution for WHO's data processes will reportedly be ready by May 2022.

Business processes were noted as highly relevant and necessary changes, but have seen considerable delays. However, there is positive movement on two initiatives of concern to many interviewees – supply chain process and recruitment. Developments include the hiring of a Director to oversee the new Supply Chain process in the last quarter of 2020. Interviews suggested that this emerged as a greater priority in the context of COVID-19, and also emerged as a priority in some Country Functional Reviews, however, implementation of recommendations in Country Functional Reviews have not yet been realized.

In respect to recruitment, which is well recognized as being very slow and problematic, aggressive targets on timelines were instilled in order to shorten the recruitment time period. A newly established office, in

Budapest, for that function is expected to soon be fully operational and able to make progress on reducing bottlenecks and ensuring a fit-for-purpose workforce. Job descriptions have also been more standardized, an action item prioritized as a 'quick win'. Performance Management initiatives are rated as fully implemented, however interviewees suggested the need to revisit how alignment of personal objectives are reported on and for the values expressed in the Values Charter to be more clearly incorporated into manager performance assessments. In addition, incentives tied to performance have not been institutionalized. As such, the scale up and value of this initiative has not been seen.

A new, aligned, three-level operating model



Substantial Progress Made

The structural alignment exercise required to support the roll out of WHO's new, three-level operating model and its four pillars, was completed in 2019 in HQ, and in the African, Eastern Mediterranean, South-East Asian and Western Pacific Regions, and more recently in the European Region. New offices, divisions and positions created or reconfigured under the new aligned structure, such as the Chief Scientist & Science Division, Division for Data and Delivery of Impact, and divisions for Emergency Preparedness and Response established in HQ, have been well tested over the past year. Significant work was done to enhance WHO's country operating model – needs have been captured through more than 80 country reviews in 4 regions with more continuing to be done to articulate different models of fit-for-purpose and how these will be funded.³⁶ Work was carried out to more clearly define roles and responsibilities of each of the levels of the Organization, and this is key to achieve a number of HR-related goals (including career pathways and mobility). An area with more recent progress is the new corporate service delivery model, in particular the supporting initiative to roll out a new Enterprise Resource Planning system (ERP). This work is well underway and the new ERP is expected to be fully deployed in 2022, with selection of a service provider imminent. Interviewees noted that this will be a heavy lift for the Organization and will have a bigger impact on improving business processes. A milestone has just been reached on a long-awaited initiative that was one of the quick wins – clarity on delegations of authority has just been set out. For the first time there is an agreed set of delegations (finance, procurement, travel, human resource, etc.) that provides for a minimum common denominator across major offices. A significant amount of effort was reportedly required to accomplish this.

A new approach to partnerships



On Track

This workstream has focused on modernizing WHO's approach to external partnerships. It aims to streamline WHO's approach to high-level political engagement and advocacy for health, while taking the lead on health-related SDGs in collaboration with different UN agencies and other development partners. The workstream also encompasses engaging with the UN as part of the new UN reforms, while strengthening relationships and networks and forging new partnerships to contribute towards the health agenda. The 2020 progress report indicated three of the four initiatives as being fully functional. Although Global Leadership in Support of Health-Related SDGs was rated as partially implemented, likely due to the fact that the work of the overall Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP) partnership itself was in an early phase of implementation, there have still been substantial accomplishments, particularly on the SDG3 GAP. Fifty-four percent of survey respondents (395 out of 732) expressed satisfaction with the progress of this workstream.

³⁶ For details on the country reviews and key findings see [WHO transformation – Transforming for enhanced country impact](#) (EB148/32), 4 January 2021.

Collaborative and results-focused culture



On Track

The findings of the 2017-18 staff baselines survey highlighted challenges faced by WHO staff in contributing to WHO goals and in conducting their day-to-day work. The relevance and importance of this workstream is more than ever now, to transform WHO into a more responsive Organization by promoting a more results-focused, collaborative and agile culture across WHO at all three levels. The specific focus of initiatives within this workstream include enhancing collaboration across and within the three levels of the Organization, enhancing communication at three levels by use of new tools, and promoting agile ways of working. The 2020 progress report indicated that two of the workstreams are fully functional with major achievements being the establishment of the Strategic Priority Coordination Group, the Technical Expert Networks, and Output Delivery Teams that facilitate horizontal and vertical coordination and integration across all the three levels (helping to break down silos), as well as the e-workflow platform which is accelerating and enhancing clearances and approvals for some business and administrative processes (a prerequisite for becoming a more agile Organization). The Agile Ways of Working initiative was reported as being partially implemented but data from the evaluation suggests that the past year has boosted organizational agility, although efforts need to continue.

Predictable and sustainable financing



Substantial Progress Made

This workstream encompasses improving quality, predictability and sustainability of financing for WHO. The initiatives under this workstream ensure that WHO is adequately resourced to deliver on the strategic priorities of GPW 13 as well as the health-related SDGs. One initiative is complete - the WHO Investment Case and Partners Forum. The new WHO Resource Mobilization Strategy is in place. Progress with the establishment of the WHO Foundation to better enable WHO to engage in new areas of financing includes the recent appointment of a CEO. Just forty-three percent of respondents (315 of 731) were satisfied with progress in this area, however this is likely to be a reflection on the amount of flexible funds raised and not on the structures and systems being put in place.

Motivated and fit-for-purpose workforce



Some Initiatives Still Lagging

This workstream aims to build a diverse, motivated and fit-for-purpose workforce to effectively deliver the GPW 13 agenda in the context of the SDGs and UN Reform. Of the eight initiatives, one is complete - New guidelines to Recognize Experience of National Professional Officers (NPOs). Three are reported as being fully implemented - New Measures for Short-term Developmental Assignments (STDAs), Global Mentorship Programme, and the Global Internship Programme. Two of the initiatives, Global Leadership & Management Training and Professionalizing Staff Development and Learning through the WHO Academy were reported as being partially implemented. The Academy has launched its first on-line courses. Four initiatives are noted to still be in initiation phase. Two of these just established Task Forces at the end of 2020 so more progress should be expected in 2021 - New Flexible Working Arrangements, and New/Enhanced Contracting Modalities. The latter has moved further ahead. Various initiatives were kick-started with ideation support from the G-Force Taskforce, including the Talent Pool, Career Pathways, and Flexible Working Arrangements. Global Geographic Mobility was the most frequently raised of these

issues during the evaluation (within 35% of interviews) – a new policy has been developed and a simulation exercise is expected to be completed within the next three months. Half of staff commenting on mobility in interviews provided critiques, noting that initiatives were faced with much resistance and haven't progressed. According to the survey, Fit for Purpose Workforce, has the highest percent of dissatisfied respondents (20% or 146 out of 732) and the most even distribution across the answer options. Forty-three percent expressed satisfaction.

Outputs/activities that have been particularly timely, relevant and/or well received

Very few activities were identified by staff interviewed or engaged in focus groups as not being useful. One exception was the new HQ structure which was clearly challenging on a personal and professional level for many, both in respect its design and the way it was announced. Otherwise, there were concerns expressed about the sheer number of actions being undertaken and the impact those had on existing workplans. There was apprehension about the impact on field staff, particularly those in smaller offices, having to respond to requests for input on so many things, often with tight turnaround times. Several staff also expressed concerns about Transformation being a huge tent under which all new ideas were framed, and the difficulty of having to be positive about all these ideas for risk being perceived as not being “on board” with the Transformation.

The slow pace of Quick Wins was a shortcoming frequently raised in this review. A plan for their implementation was approved by the Global Policy Group in 2018 with an expected implementation period of six months. All but one, Standardization of Position Descriptions, were reported as being complete in December 2018.³⁷ The evaluation, however, found mixed evidence on quick wins and their impact on ownership of the Transformation; a stated reason for their introduction.

The boxes below capture some of the outputs and activities that evaluation participants noted as being particularly timely, relevant and/or well received.

³⁷ The degree of completion on two wins is unclear.

<p>Delivery Stocktakes</p> <p>were cited as being an important innovation for demonstrating progress towards the 3B targets.</p>	<p>Programme budget process</p> <p>and move to the results reporting. The last PB was framed in 3B terms and in the previous way of reporting required by auditors. The upcoming report will be on outputs and 3B results areas.</p>	<p>New organizational strategy</p> <p>and alignment of work with that strategy - 68% of survey respondents rated this positively with 32% being highly satisfied.</p>
<p>New operating model</p> <p>55% of survey respondents were positive about the new model.</p>	<p>Improved RBM processes</p> <p>Interviewees felt that planning is better, and appreciated the linkage between planning and implementation – and the support of the work of the Monitoring and Evaluation Committee.</p>	<p>WHO Academy</p> <p>Interviews felt that it is an important and timely initiative, but don't actually know much about it.</p>
<p>Supply chain</p> <p>processes under covid were widely praised.</p>	<p>LEAD challenge</p> <p>enabling staff-driven ideas is seen as important for organizational improvement and making innovation apart of WHO's culture.</p>	<p>Strengthened organizational culture and staff engagement</p> <p>53% of survey respondents positive about progress towards impact-focused, collaborative and agile culture across all major office and levels. This question also elicited the second highest percent of dissatisfied respondents (16%).</p>
<p>Values Charter</p> <p>most felt it was a positive exercise and was setting clear guideposts. Some interviewees said it was creating change in their office, but some felt it was empty words.</p>	<p>G-Staff Task Force</p> <p>an outcome of the open-door policy, was applauded for being the first structured opportunity for G-Staff, specifically, to have a voice in major decisions processes initiated at HQ, it is being adopted in some regions.</p>	<p>External engagement and partnership</p> <p>54% of survey respondents were positive about WHO's modernized approach and its potential for more effectively leveraging public and private resources. The Investment Case, in particular, was welcomed.</p>

The evaluation also looked at key factors that appeared to enable and hinder progress in the implementation of the Agenda. Those highlighted below reflect an analysis of common themes that emerged from interviews and surveys.

Factors enabling the Pace of Transformation Rollout

- Enthusiasm for change and greater participation led to a substantial portion of staff being invested in the Agenda. Staff were clearly behind the need for substantial reform and the DG was consistent in articulating his vision and the case for that vision. Chart 12 below shows that 49% of survey respondents felt they have personally been a 'change agent' and contributed to the

Transformation objectives, and that 41% can link Transformation to positive changes in their work.

- The Global Transformation Team, as well as their regional counterparts, was well situated (with frequent access to the DG), well resourced (in terms of having dedicated staff positions and a sizeable budget for engaging external expertise), and persistent.
- The Country Strategy and Support (CSS) Department and its regional network which has functioned effectively as a key resource for countries, particularly for Transformation and pandemic response activities. The recently established WhatsApp group to link the network with WRs facilitated agility.
- Dialogue on Transformation work has been encouraged and continued throughout the pandemic response.³⁸ The Global Policy Group, establishment of networks and taskforces such as the G-Force, and focus on measurement and achievement of the GPW 13 has positively shifted the Organization towards communicating and operating as one WHO with accountability to results established across departments and the three levels.

Factors that have hindered progress

The evaluation concurs with the findings of the Independent Oversight and Advisory Committee (IOAC) for the WHO Health Emergencies Programme³⁹ that:

- “The centralizing of business processes, such as human resource management and other cross-cutting functions, has yet to fully deliver on its ambition of greater efficiency and organizational cohesiveness”, and
- “Organizational culture and administrative system continue to resist change”, in some offices.

Other hindering factors identified in this evaluation include:

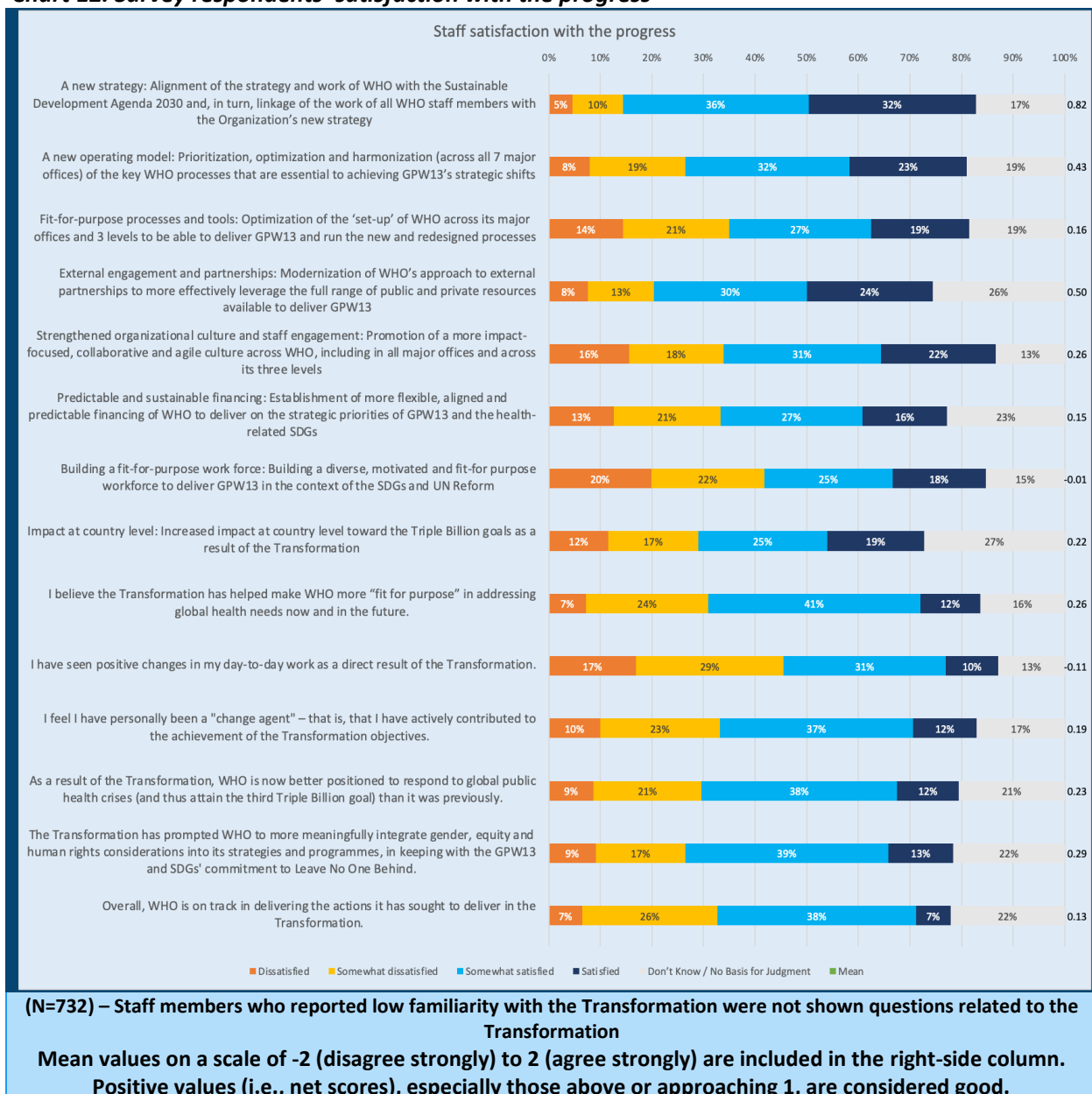
- Gap in flexible funding to enable country plans and even centralized functions, such as human resources, as funding earmarked more for technical programs, which hindered some objectives, including better cross-collaboration across levels.
- The varied levels of expectations for engagement of Member States in the agenda.
- Business owners were not well involved in the preliminary design stage to the extent they would have liked to have been, and were not handed over the processes with clear deployment strategies and accountability mechanisms in place.
- The time taken to design the strategy lasted almost two years, in part because of the desire for it to be consultative and not be externally or donor-driven. Although cross-cutting engagement in the design phase appears to be leading to better results, it has also contributed to reform fatigue.
- The large number of Transformation activities made it difficult to maintain momentum on all fronts. The Change Agent network is an example of where a significant investment of staff time was made in establishing the network but where there wasn't sufficient support for implementation. The African Region is again an exception as this function is prioritized with monthly Change Agent meetings being held.

³⁸ IEOAC Report 31st Meeting (30 June-1 July 2020) shows the desire for continued dialogue with staff about Transformation even during pandemic “Rec V - Senior management to ensure continued two-way dialogue with WHO staff so as the spirit of transformation is not lost and staff at all levels feel a sense of ownership for the transformation and that any concerns are being heard.”

³⁹ [Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme – Looking back to move forward](#) (A73/10), 4 November 2020.

- The focus on structural reorganization in the early phases of the Transformation's implementation, including the extent of reorganization and the hard mechanics of redesigning the structure, caused delays and unrest, and created a fragile base for the Transformation workstreams to bounce off of.
- The time taken for some of the Regions to come onboard, and not having full-time staff dedicated to the effort or resources made available for this.
- COVID-19 pulled the attention of staff across levels and the resources needed for the response clearly interrupted the Transformation's implementation. Despite the halt on the implementation of key processes, there was also general agreement that the work changes necessitated by the pandemic also played a role in moving targeted pieces of the Agenda forward, primarily, increased Organizational agility.

Chart 12. Survey respondents' satisfaction with the progress



Considering the size and reach of WHO, that it is an international organization with a decentralized structure, the breadth of change, and the interdependencies of many of its systems, progress has overall been substantial. The key pieces that have been slower do appear to be on track to be substantially implemented by end of the year. Transformation has stretched the Organization, with several of the staff interviewed noting that they are over-extended, particularly with the weight of the COVID-19 response. Forty-five percent (45%) of staff felt satisfied that WHO is on track in delivering on Transformation, with 33% feeling dissatisfied.

The formal establishment of the Transformation Implementation and Change Office in quarter three of 2020⁴⁰ (formerly known as the Global Transformation Team) is important for rebuilding the momentum of the Transformation post-pandemic and sustaining and solidifying progress made. It demonstrates significant organizational commitment to providing continued support to business owners, tracking progress, as well as continuous improvement and learning. The three major areas of focus will include (i) strategy and portfolio management and monitoring (ii) catalytic implementation support, and (iii) change management, staff engagement and outreach. Performance metrics for each initiative and a Transformation Implementation Dashboard are currently being developed to more clearly track and communicate the Transformation journey.

Overall, as echoed in the staff survey (Chart 12), there was a general satisfaction with the implementation progress so far, especially with regard to strategic alignment. As seen above, this satisfaction drops somewhat when it comes to other issues such as resource alignment. This is explored and discussed next.

⁴⁰ A total of 8 positions were approved for the TIC office in August 2020 (stakeholder interview). Currently, 4 of these positions are occupied and 2 are currently under recruitment.

3.3 TRANSFORMATION RESULTS

This section discusses observable results from WHO Transformation, bearing in mind the early stages of its implementation and the formative nature of this evaluation. While the focus here is on examining the effectiveness, it also touches on impacts and cross-cutting issues of partnership and human rights and gender equity. As Transformation has not been fully rolled out yet, the impact question only assesses the likelihood of Transformation eventually delivering on its triple billion goals as outlined in GPW 13 and the health-related SDGs. The main focus here is on the achievement of outcomes specified earlier in the Theory of Change and associated evaluation results matrix in Annex V. As per the evaluation report guidance, the specific question for this section is: How effective has the Transformation thus far been in achieving its targeted objectives?

- ⇒ **Small, but significant and positive change in the Organization's culture was observed, which indicates progress towards more collaboration, flexible working conditions, and commitment to the Organization's objectives and results.**
- ⇒ **These changes are also reflected in the WHO Values Charter introduced in 2019.**
- ⇒ **Most of these changes reflect progress in strategic realignment, but not yet in resource realignment necessary for making higher country-level impacts, although WHO has made considerable progress in managing external partnerships as well as in dealing with global public health emergencies.**

3.3.1 *Organizational culture*

This section reports findings on outcome 1.1 from the evaluation results matrix/ theory of change, which relates to WHO developing a more agile, results-oriented, innovative, adaptive and collaborative organizational culture.

In its previous organizational culture survey conducted by McKinsey in 2017-18, WHO was ranked in the bottom quartile of all organizations and below average among public and social sector organizations, which, McKinsey suggested, compromised WHO's ability to achieve its performance goals as the key weakness of WHO's organizational culture.⁴¹ There is a widespread recognition at WHO on the need to change. Citing Drucker's famous quote "Culture eats strategy for breakfast", several top leadership interviewees highlighted a number of initiatives undertaken by WHO to transform its organizational culture and the necessity to focus on culture as a precursor to achieving other systems- and process-level changes. WHO Values Charter, change supporters' network, open-door policy, World's Healthiest Organization, #ProudToBeWHO and Global Task Force on Flexible Working Arrangements are some of the major initiatives introduced by WHO in this realm. These initiatives are fundamental to the overall goal of transforming WHO into a modern, results-oriented, agile and collaborative organization managed towards delivering health-related SDGs.

There is also a widespread acknowledgement that changing organizational culture is a hard process that requires sustained investment of resources and effort over a relatively long period of time. It is, therefore, noteworthy that some progress in transforming organizational culture is already visible. Chart 13 below

⁴¹ WHO Culture Change Update, A briefing on 21 December 2018 (PowerPoint provided by the Transformation team).

maps out common elements from the McKinsey (2017-18) and DeftEdge (2021) staff surveys.⁴² Before elaborating on various elements of organizational culture, it is worth highlighting that WHO has made a small, but statistically significant,⁴³ positive change in its overall organizational culture. As can also be noticed, the biggest difference is in staff's belief that they are heard and valued,⁴⁴ which can be directly linked to policies such as those on open-doors, staff well-being, task forces, change agents' network and pulse surveys. A vast majority of the interviewees across all levels and stakeholder groups concurred that Transformation was undertaken after extensive consultation, and that staff were provided adequate opportunity to submit their suggestions for organizational change.⁴⁵

While there was an increase from baseline in staff ideas and expertise being respected, this area, as mentioned, was also more poorly rated as it related to inputs on Transformation design and implementation, specifically. This points to how undervalued staff have previously felt within the Organization, and while progress has been made, more significant efforts are required to ensure this momentum continues and that cohesion and innovation, and progress on the Transformation objectives, are not stifled by closed and hierarchical management styles. The overlapping curves in the chart also capture the extent to which culture is intractable to change. While there is no progress in several areas (discussed in the succeeding pages), a minor area of concern is the perceptions on autonomy and cross-collaboration, for which scores were slightly lower than in 2018. This is something that WHO may need to monitor closely going forward.

The culture survey in 2017-18 had specifically examined leadership and three organizational capabilities (Alignment, Execution and Renewal). Each of these capabilities was divided into a number of outcomes. Alignment examines whether staff were aligned around the Organization's vision, strategy, culture and values. It included questions on strategic direction, communication of compelling vision, and cultivating consistent values and norms to foster effective workplace behavior.⁴⁶ Execution pertains to employees' ability to deliver with their current capabilities, processes and motivation level. It includes questions on accountability, coordination & control, capability and motivation.

Lastly, renewal pertains to the Organization understanding, interacting, responding, and adapting to the external environment. It includes interaction with its stakeholders as well as harnessing new ideas and innovations. Following the methodology used in 2018 survey for comparative purposes, the evaluation tallied the proportion of staff members who agree (or expressed satisfaction) with each of these outcome criteria.

The evaluation found that the mean score on six questions pertaining to strategic direction was slightly higher than that in 2018 (62.5 against 60). In particular, the biggest improvement was observed on the question about the alignment between WHO's vision and its strategy (70%). Other questions on the survey and interviews confirmed that WHO had made substantial progress in promoting strategic alignment. While regional variations are discussed below, staff in general perceived a greater alignment between organizational goals (health-related SDGs) and their work.

⁴² Note that the evaluation used an abridged version of the 2018 culture survey instrument in order to keep the survey questionnaire to a reasonable length. The evaluation survey included additional questions specific to Transformation results and hence had to leave out redundant questions from the 2018 survey. The data from the organization cultural survey is incorporated in Charts A6-A10 in Annex X.

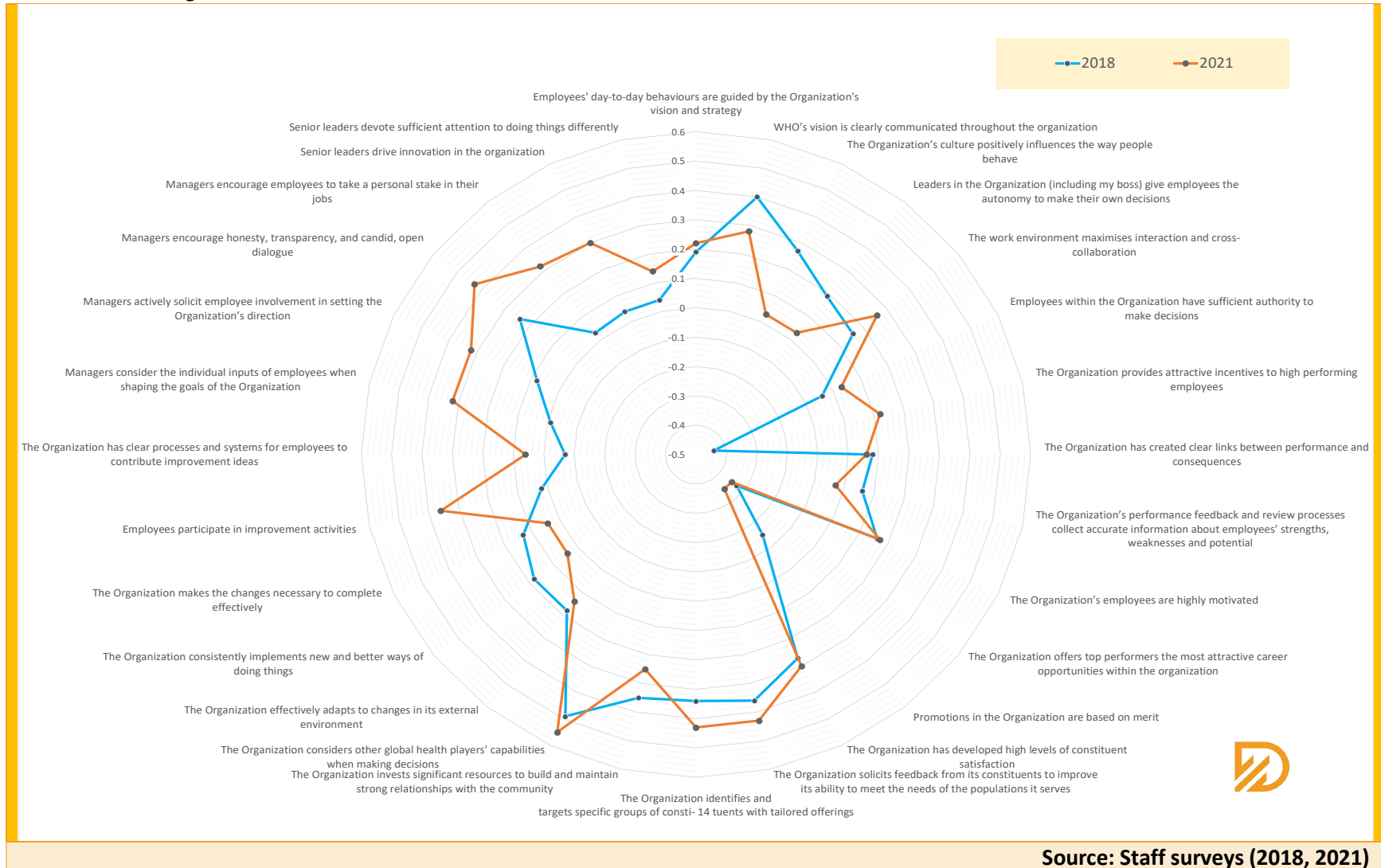
⁴³ t-test for two sample means (0.175 in 2021 against 0.115 in 2018, $p < 0.001$) provides evidence for significance.

⁴⁴ Top-left corner, where orange line significantly extends outward from the blue line.

⁴⁵ Though, many also noted variation in the extent to which these changes had percolated down to lower levels of the Organization or in the extent to which their suggestions were actually considered.

⁴⁶ Leadership is discussed separately as a cross-cutting theme.

Chart 13. WHO Organizational culture over time



The average scores on work environment (57 v. 53), coordination & control (67 v. 47), external orientation (63 v. 48), innovation & learning (57 v. 42) and motivation (61 v. 50) were higher, while accountability (54 v. 56), and capabilities (75 v.77) were slightly lower.

While some of these observable changes may have resulted from the vagaries of sampling or from using an abridged version of the questionnaire, a general improvement in culture was also perceptible from other questions on the survey as well as from interviews with stakeholders across the three levels of the Organization. Accountability, including performance management, incentives and consequences, however, was frequently highlighted as an area of concern: Only 43% of the survey respondents found that WHO has used performance management system towards managing for results. This was echoed in interviews, in which staff assessed some key activities of the Transformation, such as centralization of communications, human resources, resource mobilization through the WHO Foundation, had perhaps weighted decision-making and accountability in HQ, contrary to the objective of further delegating authority to increase country impact.

Transforming culture

- ⇒ **The evaluation finds a small and positive change in organizational culture. This is visible mostly in the perceptions on feeling heard and valued, which indicates progress towards breaking down hierarchical structures.**
- ⇒ **The evaluation also noticed a small increase in dissatisfaction pertaining to incentives and disincentives for performance.**
- ⇒ **Evidence also points to intractable elements of culture that will need greater attention on an ongoing basis for pushing WHO towards its target changes.**

The evaluation specifically explored a change in organizational culture as a result of Transformation and included twelve questions pertaining to areas of culture that WHO has targeted through its Transformation efforts. As seen in Chart 14 below, about half of staff survey respondents (between 43%-58% for various questions) agree and about a third disagree that Transformation has made WHO a more results-oriented, agile, innovative and collaborative Organization. There were, however, significant regional variations. Staff in the African Region, which started its transformation prior to the rest of WHO, were significantly and consistently more positive across all culture-related questions, while staff at HQ exhibited a large amount of heterogeneity in their responses (and were overall negative in their assessment).⁴⁷

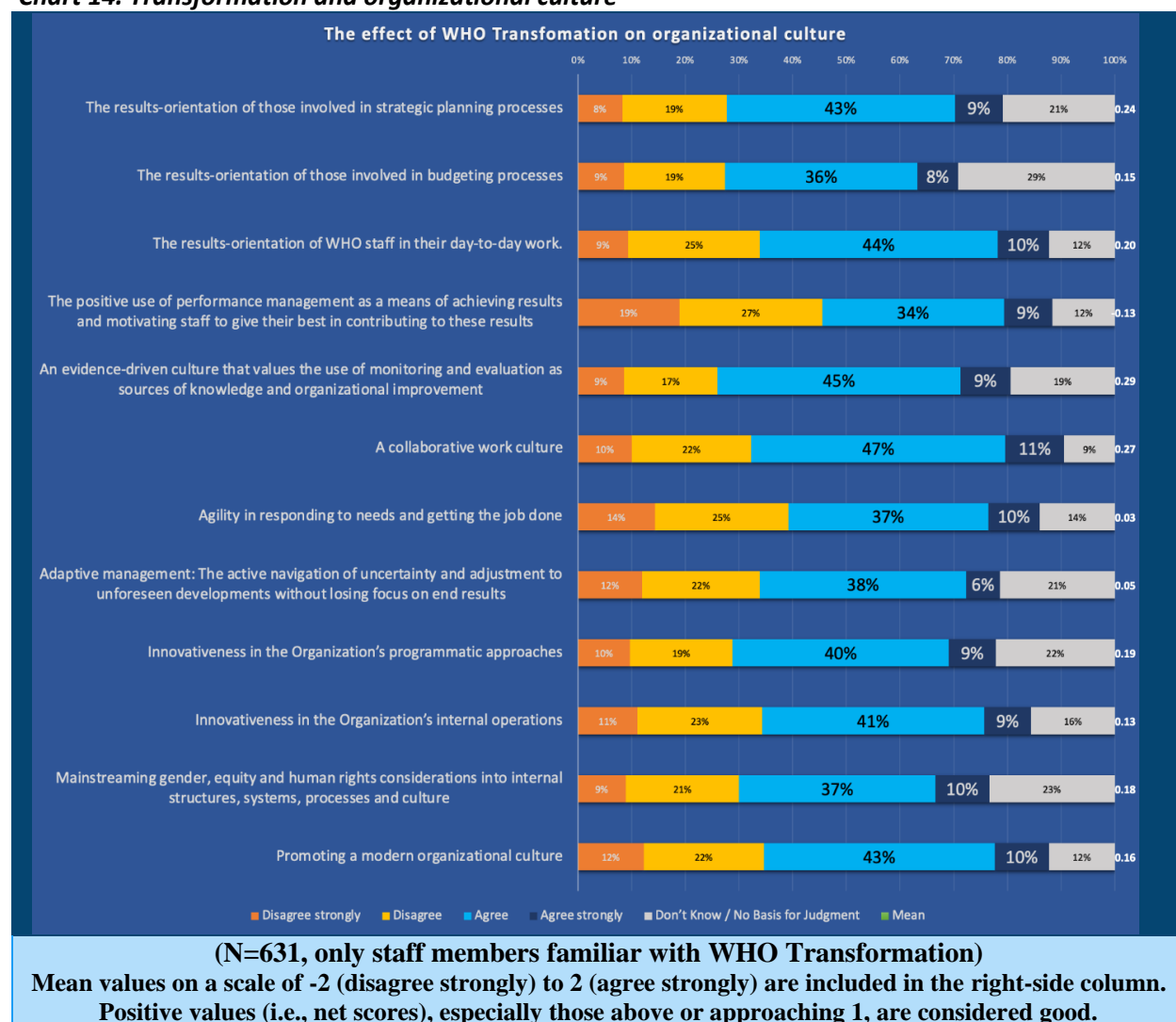
⁴⁷ Interviews suggested that many HQ staff were affected by and unhappy with the recent restructuring of HQ and how that was done.

Chart 15 presents an overall score on transformation of organizational culture. This score was computed on the basis of factor analysis, which showed that these twelve questions really captured one underlying dimension (i.e., cultural transformation).⁴⁸ The average scores (both mean and median) for cultural transformation in

⁴⁸ Factor 1 had an Eigen value of 7.91 and no other factor had an Eigen value higher than one. All questions had factor loadings higher than 0.5 (0.74 to 0.84), and Likelihood Ratio (LR) test ($\chi^2=5718.65^{***}$) suggested the items were indeed a single underlying factor. Moreover, average inter-item variance was 0.88 and Cronbach's alpha was 0.95, thus providing further evidence for this to be a reliable scale for measuring cultural transformation at WHO. Note also that each item separately also revealed patterns similar to those depicted above.

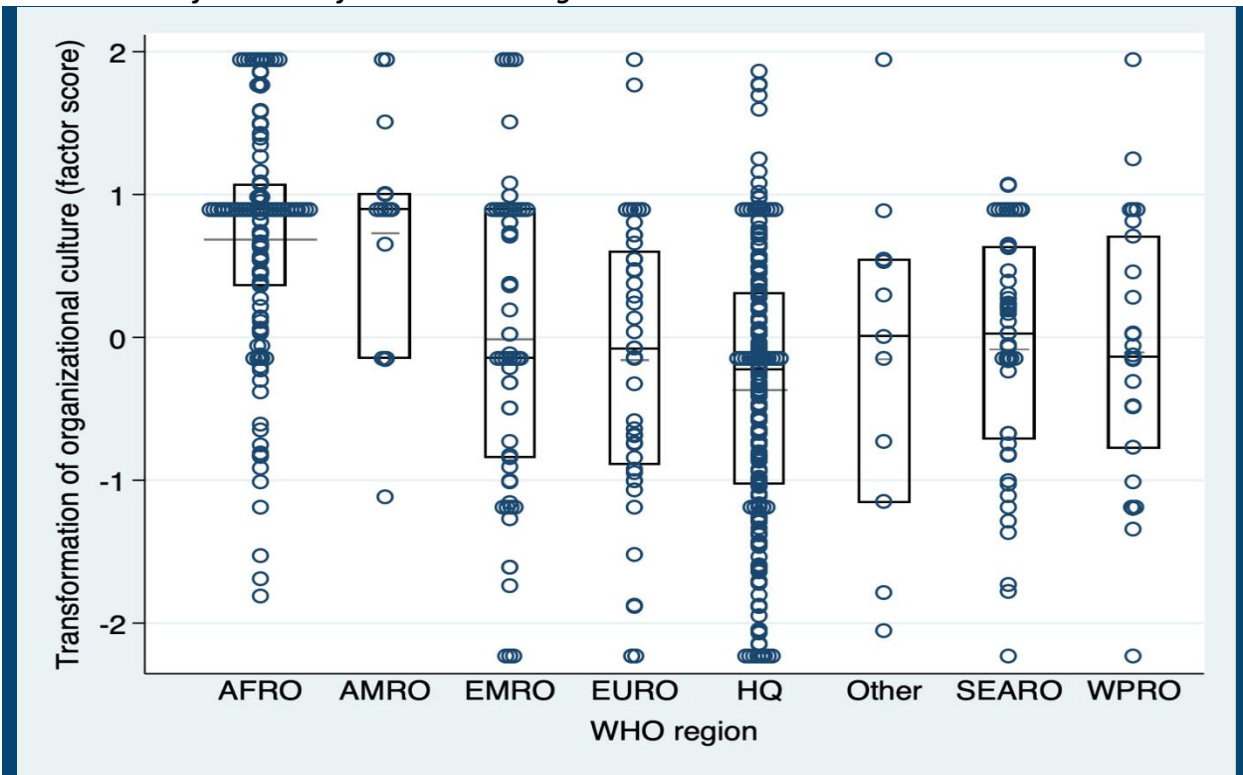
Chart 15 are higher in the African Region than elsewhere. Noticeably, HQ staff not only awarded lower, but also widely divergent scores (as indicated by the range and frequency of scores). As is to be expected at this stage of rollout of Transformation, staff in regions such as the Eastern Mediterranean and South-East Asia are neutral on the transformation's impact on culture.⁴⁹ While the evaluation also did not find differences in these scores by gender (male, female) or role (administrative, technical or other) types, it did notice that professional and higher category staff at HQ awarded slightly lower scores than professional staff in field (ROs or WCOs) or other categories of staff anywhere. Further, those who self-rated higher familiarity with Transformation awarded lower scores.

Chart 14. Transformation and organizational culture

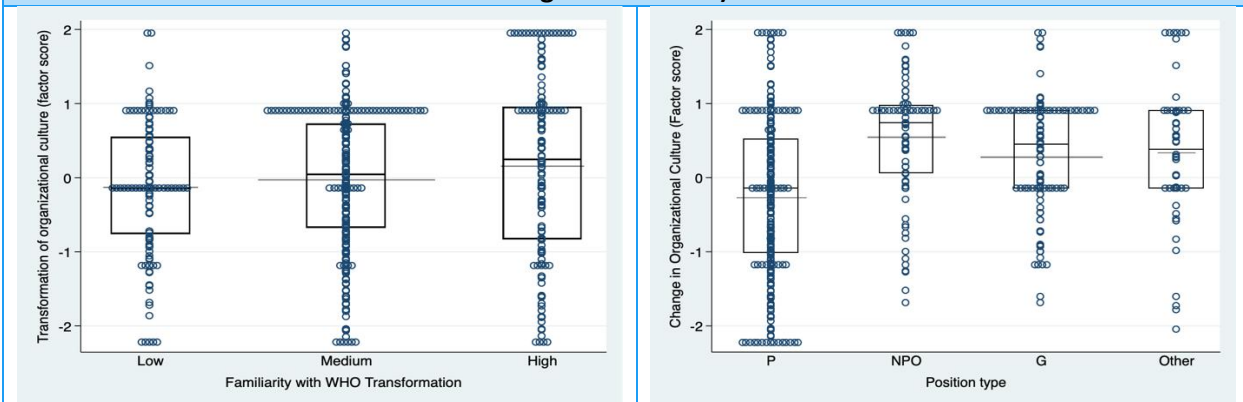


⁴⁹ The mean score are as follows: AFRO (0.68), EMRO (-0.01), EURO (-0.16), HQ (-0.37), AMRO (0.73), SEARO (-0.08), WPRO (-0.11) and Other (-0.15). Data on AMRO is rather sparse, so any conclusion should be drawn with caution.

Chart 15. Transformation of WHO culture: Regional variations

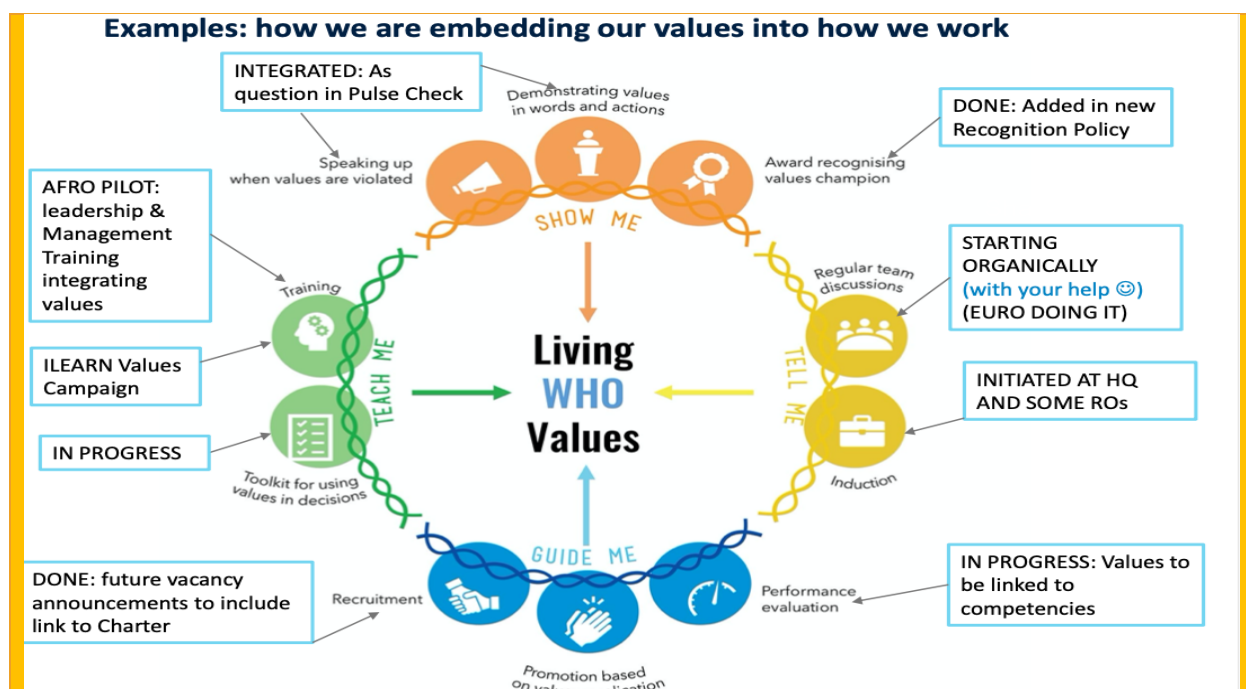


(N=607, only those staff members, who are familiar with WHO Transformation and shared their regional location).



Qualitatively, initiatives such as WHO Values Charter, Change Agents' Network, World's Healthiest Organization, and #ProudToBeWHO are very promising efforts at inculcating new cultural values and norms. Discussing in reverse order, #ProudToBeWHO was highlighted by interviewees as an initiative that promoted allegiance to WHO rather than its regional units. By promoting a sense of staff well-being, World's Healthiest Organization initiative could potentially build a greater sense of allegiance to the Organization. Flexible working arrangements, necessitated by the ongoing pandemic, could potentially increase focus on ownership and accountability for results. Creation of change agents' network and task forces such as G-Force have increased the emphasis placed on collaboration. In interviews, several respondents from the African Region highlighted the change agent network as a positive change quite

frequently. The introduction of WHO [Values Charter](#) is similarly a potentially groundbreaking effort (see box).⁵⁰



WHO values charter introduced in 2019 seeks to embed five core values in WHO's work.

It states that, "As WHO staff, sharing the vision with our Member States of "a world in which all people attain the highest possible standard of health and wellbeing" and a common mission to "Promote health, keep the world safe and serve the vulnerable", we are / stand for:

- 1. Trusted servants of public health/ Trust in our service**
We serve people's interest, above all
Our actions and recommendations are independent and evidence-based
Our decisions are fair, transparent and timely
- 2. Excellent professionals for health / Excellence for health**
We uphold the highest standards of professionalism across all roles and specializations
We rely on scientific evidence and technical expertise
We continuously develop and drive innovation to respond to a changing world
- 3. Persons of integrity / Integrity**
Our actions match our words and we model the recommendations we give to the world
We engage with good faith and honesty with everyone
We hold ourselves and others accountable for what is said and done
- 4. Collaborative colleagues and partners / Collaboration for impact**
We engage with colleagues and partners effectively to maximize our common impact
We recognize and use the power of diversity to go further together
We communicate openly across all roles and learn from one another
- 5. Humans caring for humans / Being humans**
We courageously and selflessly defend everyone's right to health
We show compassion for human beings, their health and wellbeing

⁵⁰ WHO Values Charter HQ induction presentation, 26 November 2019.

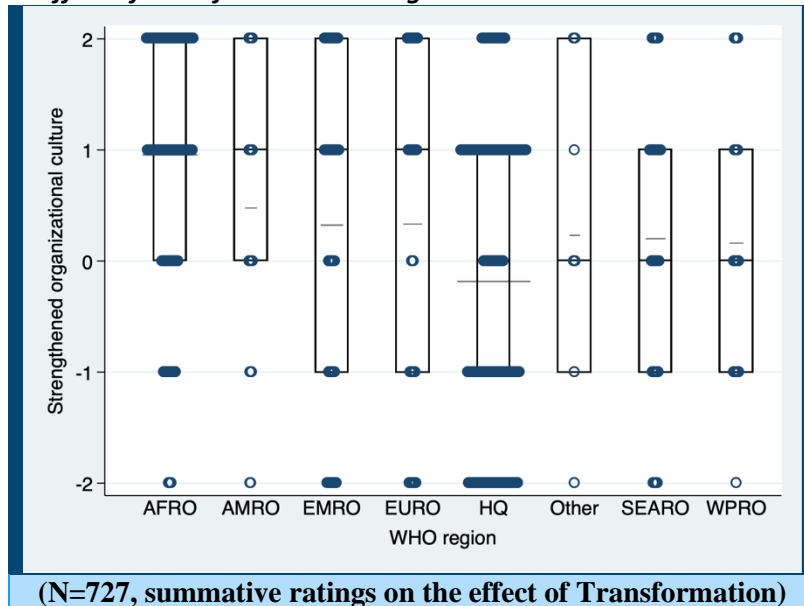
We make everyone feel safe, respected, empowered and fairly recognized

A substantial majority of interviewees recognized the potential value of these significant initiatives. In staff's assessment, the Transformation has core values, some of which have always existed (e.g., respect in the workplace initiative and change agents), but these were not consistently applied; while others highlighted how the Values emerging from the Transformation aligned the Organization around shared and common vocabulary. Similarly, a simple fact of engagement and conversations with staff, for many, was a transformative experience, but for others, it did not go far enough. Several staff members (about half of HQ staff interviewed) remarked that while Transformation initiated conversations, these were often top-driven or their ideas were being listened to, but not really heard or acted upon, as previously noted. As such, in many ROs and WCOs, these initiatives have not fully taken hold, and so effects are not fully realized.

More importantly, staff also expressed concern over slowness in changing performance management systems that place value in rewarding high performers and phasing out non-performers. These concerns were especially noted by survey respondents as well as interviewees with regard to HQ, which in combination with lack of adequate staff mobility (discussed separately) was recognized to be a major challenge for cultural change. Lastly, several interviewees also highlighted the fact that WHO appears to be underestimating the amount of effort that goes into effecting cultural change. The expectation that values will be embedded into WHO's actions, processes and systems was cited as a prime example of such 'unrealistic expectations.' Stakeholders remarked that the Values Charter indeed set a standard that didn't previously exist, but it needed a lot more work to institutionalize it.

Chart 16. Summative ratings on the effect of Transformation on organizational culture

Overall, as noted earlier, the evaluation finds evidence for small, but positive and significant transformation in culture. However, as summarized by a question on summative ratings (Chart 16), the evaluation also notes regional variations in the change. The African Region, which started the transformation process earlier than the rest of WHO, shows the most promising results so far. The evaluation also notes the need to build stronger accountability and performance management systems, including providing stronger incentives (e.g., promotions and recognition) and disincentives (e.g., demotion, severance, and disciplining), to accelerate and reinforce targeted cultural changes.



3.3.2 *Internal processes and knowledge management*

Results-based planning, monitoring and evaluation

This section reports findings on outcome 1.2 from the evaluation results matrix/ theory of change, which relates to increased application by staff at all levels of results-based planning, monitoring & evaluation.

Guided by the objectives of the GPW 13 and triple billion targets, WHO sought to establish and operationalize an impact-focused, data-driven strategy through the Transformation. This included five primary processes, whose progress was previously described: (1) Aligning WHO's work with GPW 13; (2) Aligning the day-to-day work of all WHO staff with GPW 13; (3) Development of the GPW 13 Results Framework and WHO Impact Measurement Framework; (4) GPW 13 Output Scorecard; (5) New delivery stocktake mechanism. The Transformation implies a major shift. It seeks to ensure that at all levels of WHO work there is an orientation to the results achieved, especially in terms of outcomes and objectives. While reporting on outputs has been a normal procedure in the WHO as in most UN System organizations, reporting on outcomes is relatively new.

Overall, staff across all levels perceived that Transformation has brought forward a culture of results-based planning and evaluation that did not previously exist, with 75% of staff commenting on this outcome in interviews expressing positive assessments and/or at least some concrete progress. Similarly, 54% of survey respondents agreed that WHO had a culture which was evidence-driven, and that WHO staff had a results-focused orientation in their day-to-day work. The introduction of the WHO Impact Measurement Framework, the Triple Billion Dashboard, and Output Scorecard, as well as the alignment of individual performance objectives to the GPW 13 outputs were highlighted as a means to improve data systems and the availability of monitoring and evaluation tools and shift the Organization's focus towards results. As previously noted, by 2019, 74% of WHO staff globally had at least 2 individual performance objectives linked to GPW 13 outputs, which increased to 100% of staff globally by 2020, and the Output Scorecard is currently being used across major offices to complete the Mid-Term Review of the Programme Budget (March 2021).

WCO staff, in FGDs, appreciated the way Transformation had guided priorities at all levels and is driving home the importance, and practice, of working as one WHO through the application of results-based planning instruments. Qualitative responses from countries and regions suggest that having a culture of evaluation is a notable result of the Transformation. They felt that data systems being put in place could be the building blocks for data-driven decision-making, and that ultimately, tools like the Triple Billion Dashboard should be helpful for HQ to gather up-to-date statistics on diseases and deaths globally. These should also provide relevant guidance to WCOs based on trends and lessons. Similarly, 58% of survey respondents felt the Transformation had improved results-focused approaches to managing the Organization towards its targeted objectives, and 57% reported an increase in use of information and knowledge to reflect on organizational performance.

However, despite the shift in mindset and available tools/resources, there are still limits to its full application. Processes are in place, which has made the collecting and entry of data a bit easier through the online platform, but there has been inadequate training experienced at the country level to fully realize the power of the available data for driving programming towards country impact. The use of the new Output Scorecard, in the interviews, suggests that some still view it as a checkbox exercise rather than capturing country-level outcome results, which may differ by country and region, and that the

Scorecard is too complex, with too many indicators and requiring significant capacity and discipline to complete. Others see the Scorecard as an externally-driven tool which is not fit for WHO, and indicate concerns over its buy-in. As such, results-based management practices are still inconsistently applied, with 30% of survey respondents reporting that results are 'always' (19%) or 'often' (11%) made internally transparent to help motivate staff, while 48% of survey respondents felt leaders in WHO 'always' (19%) or 'often' (29%) guide organizational decisions with data and facts. This suggests that over 50% of staff are not frequently seeing or utilizing data to its fullest extent.

Triple Billion Dashboard: A significant milestone reached in November 2020 was the launch of the beta version of this [dashboard](#) which tracks progress in each country towards achievement of the triple billion targets. Previously available country data was fragmented. This initiative is important for WHO in fulfilling a core mandate of gathering country statistics on disease and death reports globally. Strengthening country data systems is a long haul and will require investment but this is an important step for determining the technical support that now needs be provided at the country level. The dashboard was initially piloted with eight countries then a further 34 before being opened to all Member States.

Some regional offices surveyed and interviewed indicate that organizational structures and capacities for evaluation require strengthening and that more evaluations of policies need to be conducted to ensure greater transparency and accountability. It was also suggested that lessons from evaluations should be better integrated into program planning and budget design to improve overall effectiveness and efficiency, which emerged as a critique also of the Transformation itself, seeing that evaluation lessons were incorporated in the design, retrospectively, though their use was not made apparent to key decision-makers in the moment. Illuminating this point, 39% of staff disagreed that WHO's reviews of organizational performance leads to appropriate corrective action.

This is reflected in the response to the survey question rating satisfaction with the progress made to date on key results, in which 27% of respondents noted that they did not know, or had no basis for judgement, on whether the Transformation increased impact at the country level toward the Goals. Probable rationale related to this area include, amongst others: 1) tools for tracking and reporting progress have only recently been rolled out and are therefore not well understood nor consistently used; and 2) it is too early in the timeline to measure results at this level.

3.3.3 *Effective knowledge management system for organizational learning*

This section reports findings on outcome 1.4 from the evaluation results matrix/ theory of change, which relates to the effective knowledge management system for organizational learning.

The WHO Academy reportedly emerged from the open-door initiative. While still in the planning phase, it has demonstrated to staff that their ideas are listened to and acted on, upholding organizational values of collaboration and respect. However, many are still unclear on the intended purpose of the WHO Academy as a different or better knowledge management system as there was minimal consultation with WCO and RO staff and Member States, and other mechanisms for learning were already in place and responsive to country learning needs, such as the Global Learning Program (GLP), International Recovery Platform (IRP), and PAHO's virtual campus. As such, without a clear plan or learning framework, nor adequate consultation on this new initiative, there is fear that it might not receive adequate budget and be sustainable in the long-term, and that the benefits of a centralized learning platform/academy might not reach Country Offices, which is the primary intent.

3.3.4 *Increased, and more cost effective, collaboration among WHO staff members*

This section reports findings on outcomes 1.5 and 1.7 from the evaluation results matrix/ theory of change, which relates to increased time and cost effectiveness in collaboration by staff across three levels of the Organization.

Changes in administrative procedures such as digitization of approval mechanisms, communication via digital platforms, and use of technology generally has led to some key results, such as strengthening internal and external communications and increasing organizational alignment across all levels.

However, for the most part, the centralization of key processes has increased the amount of time spent on some administrative processes according to interviewed stakeholders. In addition, ‘wins’ in this area were difficult to attribute to the Transformation, with the onset of COVID-19 also imposing change, either delaying some process re-design and implementation timelines or pushing forward outcomes on others. While some saw business-process changes as forming the necessary conditions to evolve during COVID-19, it is difficult to assess. However, it was clear that WHO was able to adopt new, remote and collaborative working arrangements through the use of technology during the past year.

Staff had understood that “streamlining bureaucracy” was the number one priority of the Transformation, but overall efficiencies have not yet been experienced, and the focus on structural changes overshadowed important discussions on processes and systems. Of those staff commenting on this outcome in the interviews, 72% expressed negative and/or mixed impressions of progress on streamlined business processes. Similarly, 39% of survey respondents ‘disagreed’ or ‘disagreed strongly’ that business processes were more streamlined as a result of Transformation and 18% did not know or have basis for judgment. In addition, 44% disagreed that WHO consistently implements new and better ways of doing things, and 48% disagreed that WHO is able to adjust rapidly to new ways of doing things.

For example, newly-centralized recruitment processes, especially merging recruitment for WHO and the WHE Programme, has increased the time it takes to recruit people, which negatively affects WHE’s ability to respond to urgent hiring needs brought on by country and global crises as well as negatively affecting WHO’s operations in general. According to WCOs, it still takes six months or more to hire someone. In the same way, country and regional staff interviews indicate that Transformation has not been able to ‘invert’ the ‘inverted pyramid’, which is still top heavy, further exacerbating inefficiencies and affecting WHO’s agility and responsiveness.

In addition, centralization of processes, coupled with structural changes such as the increased delegation of authority at all three levels, has potentially jeopardized accountability and risk management, in contrast to its intent. While the delegation of authority across levels coupled with the new automated portal for approvals was seen to increase efficiencies in approvals and also create a ‘paper trail’ for any potential audits, consensus from interviews also suggested that it elevated the level at which decisions were made on issues affecting the larger Organization, and particularly countries, including recruitment, budget planning and external relations. While the rationale to centralize was understood and has increased uniformity and harmonization across levels, now certain departments and offices have become “more powerful” without having sufficient knowledge of the workings across countries and divisions. Country Functional Reviews were intended to counter this, aligning processes at the country-level, however there is minimal information on whether process recommendations have been carried through (for example, issues with supply chains in Yemen have not been realized).

Ultimately, there were several references in the discussion of end-to-end business processes as being ‘flashy’ and ‘exciting’, but underneath lacking substance: it was described as adding a layer of nice fresh paint to something that is structurally unsound. In the staff survey, 34% of the respondents felt that Transformation did not bolster a culture based on ‘innovativeness in the Organization’s internal operations’, which others saw as a necessary condition to implementing the new business processes and improving agility.

Value for Money initiative in the African Region: An innovative initiative being implemented by the regional Evaluation Team looks at how the concept of Value for Money (VfM) can become more entrenched in planning, implementation and monitoring processes across the continent. Five short 3-minute animated videos have been produced that succinctly communicate what VfM is, how it has been applied in two countries and the efficiencies gained as a result. The example from Togo is about benefits from using rural training centers to conduct public health trainings instead of hosting these in the capital. The Tanzania story focuses on how VfM has been applied in the procurement and distribution of insecticide-treated nets. The videos will initially be used as part of training Programme Management Officers in 24 countries.

3.3.5 Human resource management and mobility

This section reports findings on outcome 1.6 from the evaluation results matrix/ theory of change, which pertains to staff recruitment, assignment and mobility.

Human resources are the key resources for a specialized technical agency like WHO. WHO’s ability to deliver on its agenda is closely linked to the quantity and quality of the right staff in the right place. The movement of staff between HQ and the field (regional/country/other) offices not only is good for professional development of staff, but it is also good for WHO. It circulates knowledge between HQ and the field and also helps forge common identity as one WHO, which is critical in an Organization that is unique in the international system because of its decentralized structure. Therefore, staff mobility is a key outcome for WHO Transformation.

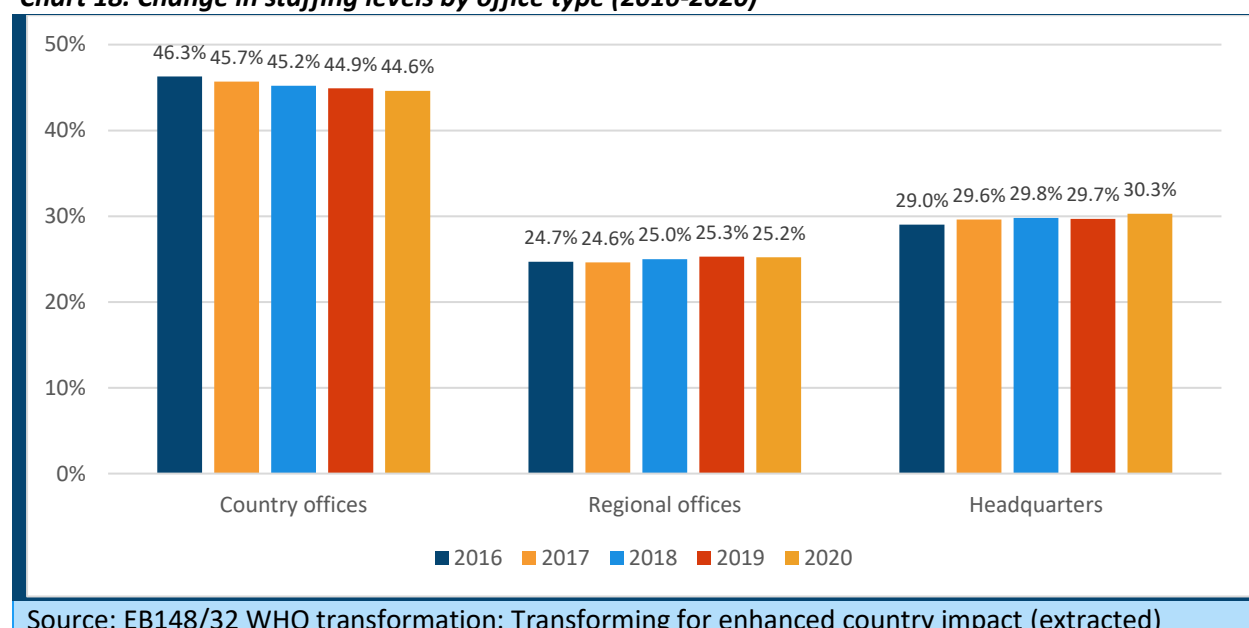
The core of WHO’s staff falls in three categories: international professionals (and higher), national professional officers and general service. In total, 8331 staff members work for WHO (as at June 2020). The total number of WHO staff has increased by about 5% since 2016.

Chart 17. Human resources by office type

Year	2016		2017		2018		2019		2020	
Office type	Number	%	Number	%	Number	%	Number	%	Number	%
Headquarters	2297	29.0%	2378	29.6%	2375	29.8%	2449	29.7%	2522	30.3%
Regional offices	1953	24.7%	1977	24.6%	1989	25.0%	2085	25.3%	2097	25.2%
Country offices	3666	46.3%	3672	45.7%	3594	45.2%	3699	44.9%	3712	44.6%
Total	7916	100%	8 027	100%	7 958	100%	8 233	100%	8331	100%

However, as can be seen in Chart 17, the rate of growth is highest at HQ rather than ROs or WCOs. In fact, the total increase in posts since 2016 is 415, of which 225 were at HQ and only 46 at the country level.⁵¹ Of 316 new hires between 2017 and 2020, 243 were in professional or higher category, and 158 of those were at HQ. The share of HQ staff in professional or higher category increased from 48.98% (1447/2954) to 50.20% (1605/3197) over this period.⁵² Most of the increase at HQ is in international professional posts (2.7%) while at country level there was almost no increase (0.7%). There was a decrease in general service posts at HQ (-2.7%). At the country level, there was an increase (4.4%) in national professional officer posts. Chart 18 shows an overview of the change in staffing levels by office type over the period 2016-2020.

Chart 18. Change in staffing levels by office type (2016-2020)



Source: EB148/32 WHO transformation: Transforming for enhanced country impact (extracted)

The problem is well-known to WHO. The evaluations of previous reform efforts have noted the HQ-heavy nature of WHO's human resource positions as well as lack of staff mobility. The most recent (2017) evaluation of WHO's reform effort noted that, "... progress on the reform of geographical mobility remains slow. Rotation has increased since 2014 but movement from HQ to ROs or WCOs is still limited." In 2016, before the Transformation started, only 162 staff members changed duty stations. In 2019, the last full year for which data is available, only 192 staff members changed duty stations (170 in 2018 and 200 in 2017). The percentage of staff, who have moved from HQ to field locations has consistently remained low (1.4% in 2019, Chart 19).

It is within this context that one of the critical components of the Transformation design was to increase staff mobility by encouraging professional staff to move from HQ to the field, especially to WCOs. However, the implementation of the geographical mobility policy was reportedly delayed. It was expected

⁵¹ WHO (2021). [WHO transformation – Transforming for enhanced country impact](#) (EB148/32), 4 January 2021. Annex 2: overview of staffing levels at who headquarters, regional offices and country offices, 2014–2020 (as of June 2020).

⁵² Chart A11 in Annex X provide more detailed breakdown of staffing levels.

to be made mandatory in 2019.⁵³ This led to a high degree of dissatisfaction among staff. Almost all interviewees in the field expressed dissatisfaction, while HQ staff had more mixed feelings on the delay. All interviewees, however, expressed concerns on the lack of incentives for field rotation and disincentives for non-rotation. Many brought up the examples of UNICEF and UNHCR, who have fixed terms for field rotation, and link field mobility to promotion and other incentives. Such a mandatory rotation should additionally encourage staff to be assigned to where the need is greatest such as in hardship duty stations and emergency/fragile countries where most of the critical work of WHO takes place. Relatedly, the selection, retention and development of high-quality WRs via independent assessment centers was also pointed out as an important issue. It was also suggested that more should be invested in career pathways and a training pipeline of next generation WRs using the example of how UNICEF deals with talent in this regard.

Chart 19. Staff mobility at a glance

	Total Professional and higher category staff	% of Professional and higher category staff	Total number of changes	% of Professional and higher category staff who has moved	Total number of changes between major offices	% of Professional and higher category staff who has moved between major offices
Headquarters	1114	49.2%	19	1.7%	16	1.4%
Africa	399	17.6%	63	15.8%	15	3.8%
South-East Asia	135	6.0%	18	13.3%	9	6.7%
Europe	241	10.6%	30	12.4%	9	3.7%
Eastern Mediterranean	191	8.4%	34	17.8%	12	6.3%
Western Pacific	184	8.1%	28	15.2%	9	4.9%
Total (2019)	2264		192	8.5%	70	3.1%
Totals (2018)	2185		170	7.8%	81	3.7%
Source: WHO Human Resources						

The main concern expressed was that the geographical mobility policy had not resulted in the realignment of resources in line with WHO's stated objective of making a greater country impact. A common example shared with the evaluation team pertained to the Tuberculosis (TB) team. Interviewees mentioned that while most of the TB cases are in South Asia, most of the staff dealing with the disease are based in HQ. Although some interviewees acknowledged that virtual working arrangements, necessitated by the pandemic, had mitigated some of the limitations of field mobility. On the flip side, interviewees were positive about the introduction of a new policy on National Professional Officers, who were to become eligible for international professional positions on completion of two years of service. This was not only expected to increase their upward mobility in the Organization, working towards diversity and inclusion objectives, but also potentially increase international professionals in the field.

A new mechanism for STDAs the global internship program, and the new BOOST Initiative have also been introduced. As of Jan 2021, 20 staff from HQ had been assigned to provide (virtual) support (technical backstopping) to WCOs through the internal BOOST Initiative coordinated through the Office of the Deputy Director-General. This reportedly enabled HQ and RO technical divisions to better understand

⁵³ A Geographical Mobility Policy for international professionals was introduced in January 2016. It was being implemented on a voluntary basis during its first three years but was expected to be made mandatory from January 2019 onwards.

country-level technical assistance needs, while also informing country teams of global proposals for specific countries. WHO is also currently running a simulation exercise to test different scenarios on how the geographical mobility policy could be rolled out.⁵⁴ However, unless staff mobility is undertaken at a much larger scale and HQ staff are encouraged to move back and forth between HQ and field (regional and country) offices, these measures are unlikely to significantly help with the circulation of knowledge or building a one-WHO identity. Thus, clearer incentives and disincentives need to be instituted to encourage staff mobility. Overall, DeftEdge notes that resource alignment and staff mobility continue to remain an area of concern for the performance of WHO.

3.3.6 Mainstreaming human rights, gender and equity

“Our mission to... promote health, keep the world safe, and serve the vulnerable ... is at the heart of our Transformation.” - The WHO Transformation: 2020 progress report.

This section reports findings on outcome 1.8 from the evaluation results matrix/ theory of change, which pertains to mainstreaming gender, equity and human rights in planning, implementation, business processes, management practices, promotions and staff structures at various levels.

The ongoing shift in WHO’s culture and ways of working, and purpose of Transformation itself, are underpinned by principles of human rights, gender equity and inclusion as well as by the values reflected in the WHO Values Charter. Through Transformation, WHO sought to create an enabling environment for greater collaboration and joint ownership of results, recognizing the distinct value of WCOs, ROs and HQ, and the individuals within them, in working together to ensure country needs and country impact are at the center of WHO’s work. This is done by removing institutional barriers to participation and promoting core values, including integrity and compassion, despite geographic, cultural, racial and gender differences. Externally, the COVID-19 pandemic, and its effect on exacerbating global inequalities, has firmly established the need for global health leadership and a strong, cohesive, and impact-driven WHO working for all countries, and thus the relevance of the Transformation.

As such, ‘gender, equity and human rights’ was included as a key results area in the GPW 13 Output Scorecard, aiming to improve the collection and analysis of disaggregated data, reducing inequities, increasing accountability for mainstreaming gender, equity and human rights, and increasing management capacity and resources for mainstreaming. One indicator directly responded to performance on the UN System-wide Action Plan on Gender Equality and Empowerment of Women (UN-SWAP), to which the DG had expressed commitment through the launch of the next generation of the accountability

⁵⁴ This is expected to be ready by the second quarter of 2022.



framework (2.0) on 22 November 2017.⁵⁵ In 2019, the second year of implementation of UN-SWAP 2.0 and of the Transformation (see above extracted image), WHO met or exceeded expectations for 5 performance indicators out of 16 applicable,

which was on par with the 2018 results but still fell far below overall ratings for the UN System broadly and other specialized agencies.⁵⁶ WHO excelled on or ‘met’ the ‘Gender-responsive performance management’, ‘policy’, ‘audit’, ‘knowledge and communication’ and ‘strategic planning’ indicators, however ‘missed requirements’ on the ‘capacity assessment’ indicator, and only ‘approached requirements’ on many others, including ‘equal representation of women’, ‘organizational culture’, ‘leadership’, ‘financial resource tracking’ and ‘gender architecture’.

The UN-SWAP ratings are reflected in the results of the evaluation. The Gender and Equity Department, which was housed under a technical programme was moved to the Office of the Chef de Cabinet to elevate it closer to WHO's Executive Leadership team in HQ for facilitating the mainstreaming of the gender, equity and human rights agenda across the Organization. By March 2021, however, there have been no identified impacts on mainstreaming efforts at different departments due to the lack of funding. It is expected, however, that in 2021 a new diversity and inclusion unit will be established “to ensure that we have a workplace where everyone feels welcome, embraced and treated with respect.”⁵⁷ The unit will oversee topics like discrimination and exclusion, based on gender, race, disability, sexual orientation, level of education and age. Interviews also highlighted the pending roll-out of a ‘Diversity and Inclusion Strategy’, and some progress seems to have been made through the posting of a request for Expression of Interest, at the request of the DG, for a consultant to develop a comprehensive Policy on Disability and an Action Plan for Implementation, though the direct link to the new unit and Transformation are not clear.⁵⁸

Gender equity increasingly reflected in management practices, processes, promotions and staff structures at various levels (HQ/ROs/WCOs).

The Director-General has directly appointed women into senior roles within the Organization, which has been positive to set an example of what could be replicated throughout the Organization. Today, there are more women in leadership positions since the Transformation started. The proportion of female heads of country office has increased from 33% in 2017 to 39% in 2019. (By way of comparison, the proportion of heads of WHO country offices, territories and areas serving outside their region of nationality has increased from 18% in 2010 to 28% in 2019, just short of the 30% target, but the proportion varies among regions.)⁵⁹

⁵⁵ WHO News: “Generation 2.0” of UN-SWAP previewed at WHO Headquarters in Geneva (Nov 2017).

⁵⁶ WORLD HEALTH ORGANIZATION (WHO) UN-SWAP 2.0 PERFORMANCE 2019.

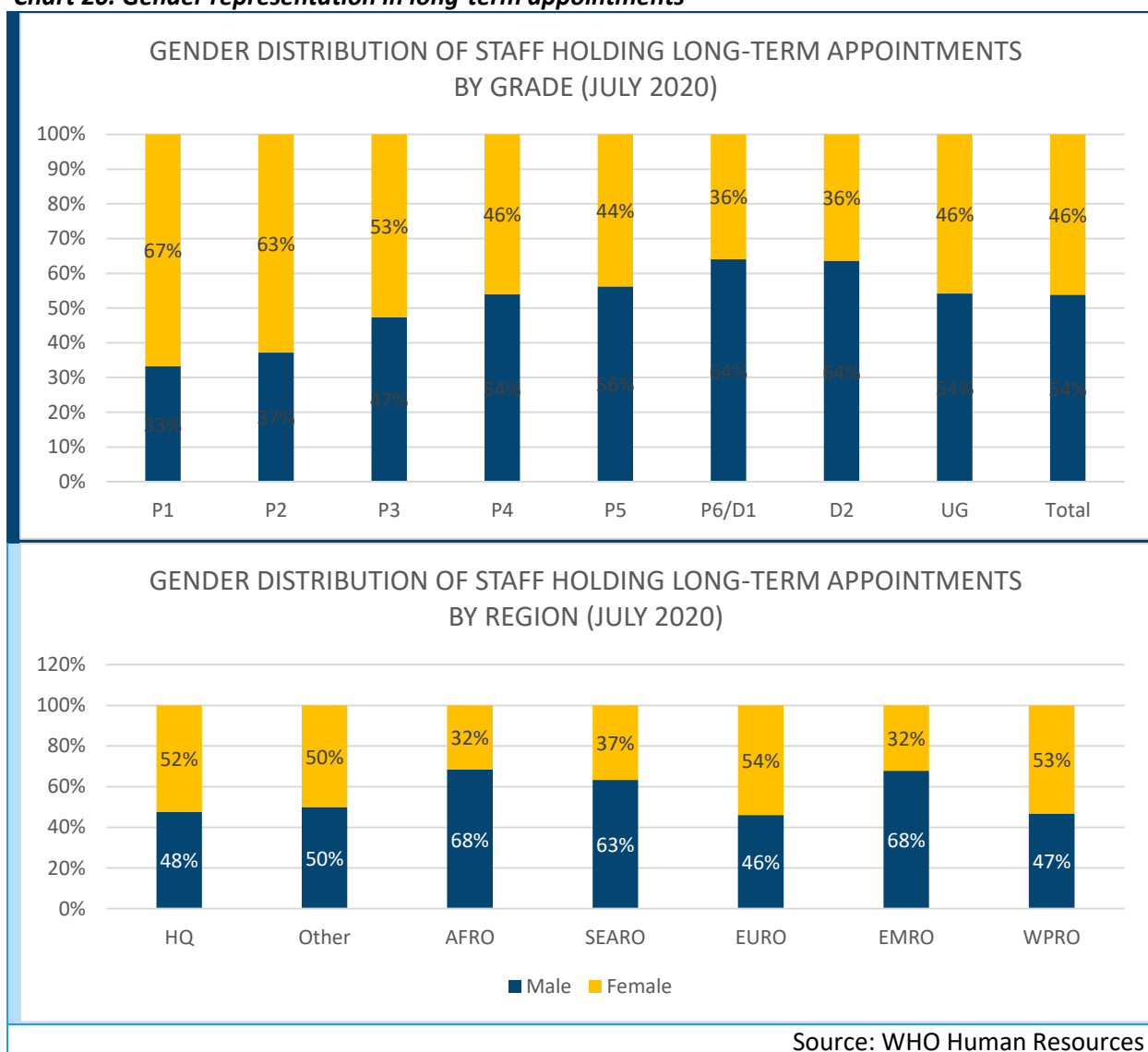
⁵⁷ WHO (2020). The WHO Transformation: 2020 progress report, p. 37.

⁵⁸ Request for expression of interest - Disability Inclusion Consultant, WHO (September 2020).

⁵⁹ WHO (2019) WHO reform processes, including the transformation agenda, and implementation of United Nations development system reform: WHO presence in countries, territories and areas (A72/INF./4), 1 May 2019.

In the last ten years, the percentage of WHO female staff holding long-term appointments as international professional staff has increased from 40% in 2010 to 46% in 2019.⁶⁰ According to a 2018 evaluation on WHO's geographical mobility policy, women accounted for 38% of the 162 geographical moves of WHO international professional staff in 2016 and for 37% of the 200 moves in 2017.⁶¹ The report also mentioned that one of the main reasons why women are less inclined to seek geographical mobility is related to family considerations.

Chart 20. Gender representation in long-term appointments



However, according to KIs, staff assessments, the standard of diversity and equity in hiring in the Organization has not necessarily been replicated at all levels. According to several key informants, there is still no gender parity at higher levels. Chart 20 shows the distribution of staff across grades

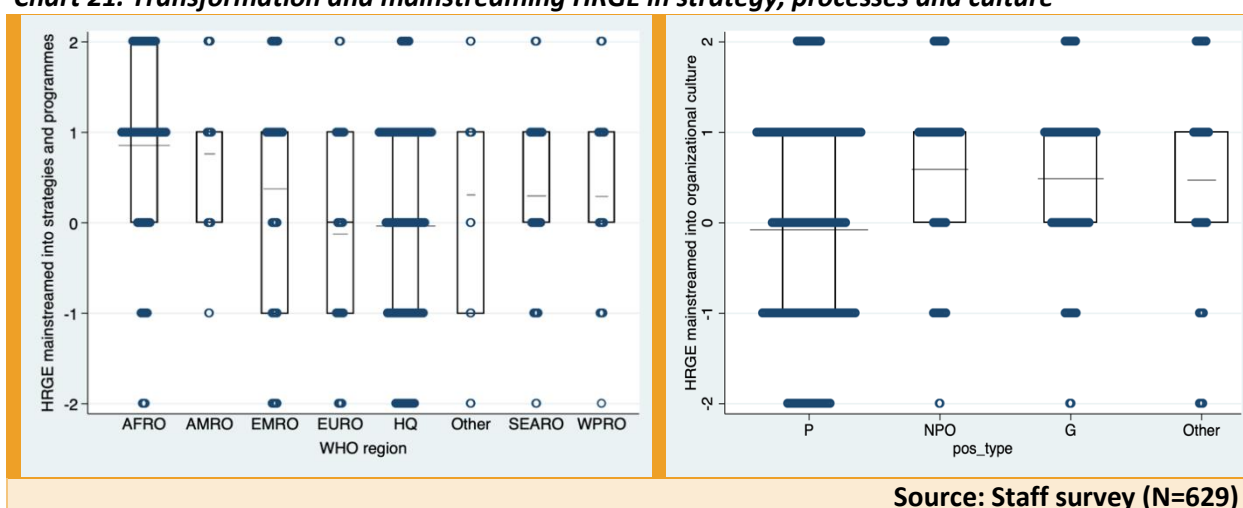
⁶⁰WHO (2020). [WHO Results Report - Programme Budget 2018-2019: Driving impact in every country](#) (A73/24 Rev.1), 10 July 2020.

⁶¹WHO (2019). [Summative evaluation of the implementation of the WHO Geographical Mobility Policy during its voluntary phase](#), January 2019, p. 3.

disaggregated by gender, with data as of July 2020. As it can be observed, at P1, there is a significant higher percentage of female staff. However, starting at P4 the proportion of females represented decreases. For grades D1 and D2, there are approximately 50% more men than women.

Additionally, Chart 20 shows the distribution of staff by region and gender. Although some major offices like HQ or the Western Pacific have gender parity overall, others, like Africa or the Eastern Mediterranean still have a significant higher percentage of male staff. Further, the hiring and equity policy has not trickled down to other positions such as technical staff or management, and a 2018 special report by IOAC found a notable lack of diversity and gender balance in the WHE Programme and at HQ. In the 2018 study, out of 1,481 WHO HQ staff, only 25% were from developing countries, and for the WHE Programme, only 24% of 229 employees came from developing countries. The gaps increased in more senior staffing levels, with developing countries represented by only 22% of staff at grade P5 or above at HQ, and 18% in the WHE Programme. Similar trends emerged for women, especially for the WHE Programme, wherein 45% of P5 category staff were women, and only 27% of directors.⁶² Although there has been notable progress in the hiring or mobility of women in certain positions, the shift to being a more inclusive culture is not yet felt throughout the Organization.

Chart 21. Transformation and mainstreaming HRGE in strategy, processes and culture



These differences are reflected in the staff survey. Only about half of all survey respondents (47%) believe that Transformation has positively influenced the mainstreaming of human rights and gender equity, while 30% believe it has negatively influenced it. These perceptions also differed across regions and staff categories. As can be seen from Chart 21, respondents in the African Region were once again more positive and HQ staff held widely divergent views on this. This trend also emerged within staff assessments, with ROs and WCOs mostly noting strong positive trends in progress towards HRGE objectives, and HQ responses showing equal distribution amongst positive, neutral and negative viewpoints. When classified into staff categories, professional and higher category staff were more likely to assess Transformation's effect negatively in this regard.⁶³

⁶² [Devex: Report finds lack of diversity, gender balance in WHO health emergencies program \(2019\)](#)

⁶³ Both these effects were statistically significant (Chi-square test for regional variations=88.7 and for staff categories variations=64.98, $p < 0.001$ in both cases).

Similarly, interviews indicated that there are differences not only at higher-level/HQ, but also at the country level. For instance, the progress has not permeated as expected. Interviewees remarked that the countries had to manage their own internal politics to mainstream gender priorities.

In response, there has been a change in HR processes to provide career progression opportunities to NPOs, who would like to be considered for international professional positions. According to the DG, this policy change arose during an open-door session from a proposal by NPO colleagues and discussions with staff. In terms of diversity, there has also been a change, in geographical representation, mostly for lower-level positions:

“As part of our Transformation, and with thanks to your ideas, WHO is taking concrete steps to promote diversity. One example is by providing career progression opportunities to national professional officers (NPOs), who would like to be considered for international professional positions. In this regard, and after the first two years of experience as an NPO, the subsequent years will count as “international experience” at a ratio of 1:1, which will allow NPOs to be considered for international professional positions. This change arose from a proposal by NPO colleagues during one of my open-door sessions, and during my visits to country offices, as well as discussions with staff” (DG Message to all staff 5 August 2020).

Other policies, such as maternity leave and flexible working arrangements, have also contributed to gender equity and empowerment goals. There has also been a focus on hiring people with disabilities in the Organization overall, but concrete quantitative data is not available to support this. Further, staff noted the lack of acknowledgement in policies and programmes of Lesbian, Gay, Bisexual, Transgender and Intersex identities, nor intersectionality, at WHO.

Other initiatives: Other gender and inclusive practices have been implemented. The ‘open door policy’ has encouraged participation of women and particularly their involvement in decision-making, especially through the active encouragement of GS-Staff to participate, who were seen to be largely represented by women (though quantitative data suggests women still only represent 46% of GS-staff), and prompt response to their suggestions and ideas. The initiative has been implemented and practiced by the DG, which staff saw as a means of dismissing established hierarchical structures and practices. Although the policy has been introduced by others, it is still not practiced by all managers across the Organization and was often described as disruptive to making progress on larger agenda items.

The Transformation introduced few internal controls related to gender equity and human rights; notably, staff were introduced to compulsory training on sexual harassment and corruption. In addition, AFRO has constituted a Gender Equity Rights Committee with representation from different Departments and human resources, which has allowed staff to raise issues on the number of women recruited and positions of women vis-a-vis men. As a result of the discussions, a training was coordinated in gender equity and human rights for the Committee members and a gender equity task force was established.

As mentioned, gender was mainstreamed into the results framework,⁶⁴ with interviews highlighting more notable progress in ‘data disaggregation and analysis’, where output indicators in the results hierarchy were more clear, measurable and easily acted-upon and monitored at the country level. This is facilitated by the Health Equity Assessment Toolkit (HEAT), which is currently in an initial development state, allowing for the monitoring of health inequalities between different population subgroups.⁶⁵

⁶⁴ WHO (2020). [Programme budget 2020–2021 WHO results framework: an update](#) (EB146/28 Rev.1), 23 January 2020, p. 13.

⁶⁵ [Health Equity Assessment Toolkit \(HEAT\)](#)

Future changes: It is expected that in 2021, among WHO's new norms and standards process, there will be "adding of new provisions in the WHO guidelines development process to improve inclusion of gender and equity considerations, enhance the use of living guidelines and support the implementation of the precautionary principles."⁶⁶

Other issues, based on previous evaluations: The Integrated Community Case Management (iCCM) is a key strategy to achieve Universal Health Coverage and reduce child mortality for WHO. Regarding this strategy, the Summative Evaluation of the WHO Rapid Access Expansion (RaCE) Initiative from 2018, recommended to conduct a systematic review of gender equality issues in the supply and demand of iCCM in different social and cultural contexts. To this suggestion, although WHO management responded that while indeed there is very little evidence around gender issues in iCCM, there were no current resources available to address this issue.⁶⁷

3.3.7 Strategic realignment and optimization for country-level impacts

This sections presents findings pertaining to outcomes 2.1 to 2.6 pertaining to increasing country-level impact. As most of the work on Transformation has so far happened at the HQ-level, findings on these outcomes are presented in a summary form in this section.

Increase in resources mobilized for country-level impacts

A major goal of the Transformation is to improve strategic planning to make WHO more effective in delivering impacts at country level. This was reflected in the new Global Programme of Work for the period 2019-2023 that was elaborated based on extensive collaboration within the Organization and which was adopted by the Member States. This was subsequently reflected in the Programme Budget for 2020-2021 and is being more reflected in the proposed programme budget for 2022-2023. The interactive process for developing this is described earlier in the findings on the Transformation Process.

Like most organizations of the UN System, WHO works on a two-year programme budget. The Transformation was initiated in 2017, which was the final year of the Programme Budget for 2016-2017 that was adopted by the World Health Assembly (WHA) in 2015. The next three budget cycles are part of the Transformation, including the proposed programme budget for 2022-2023 that will be adopted by the WHA in 2021. Chart 22 shows budgets over the four biennia.

As seen in Chart 22, the baseline amounts for the first three biennia remained nearly zero-growth in real terms.⁶⁸ This is consistent with practice everywhere in the UN System, where assessed contributions are the main source of funding and these have remained relatively unchanged. The change from 2018-2019 to 2020-2021 reflects a reduction in funding for the polio eradication which has been a long-term success story for WHO. The polio eradication funds were additional to the base segment. In addition, two other voluntary sources are included in the budget, special programmes and emergency operations and appeals. In 2020-2021 these totaled \$1,208.7 million and this has carried over to the 2022-2023 proposal. The proposed increase from 2020-2021 to 2022-2023 is largely due to an increase of \$618.5 million for what

⁶⁶ WHO (2020). The [WHO Transformation: 2020 progress report](#), p. 31.

⁶⁷ [Management Response RaCE](#).

⁶⁸ Zero real growth means that the same dollar amount is presented, adjusted for inflation and currency fluctuation.

are essentially Transformation functions as well as lessons learned from managing COVID-19 (see Chart 23). A special line for improving country capacity and functions is also proposed.

Chart 22. Approved and Proposed Programme Budgets 2016–2023 (US\$ million)

	2016-2017	2018-2019	2020–2021	2022–2023	
	Approved Programme budget	Approved Programme budget	Approved Programme budget	Executive Board Draft Proposed programme budget	Change from 2020-2021
Base segment	3,354.3	3,400.3	3,768.7	4,477.5	15%
Polio eradication	894.5	902.8	863.0	444.7	-35%
Special programmes	91.6	118.4	208.7	208.7	
Emergency operations and appeals			1,000.0	1,000.0	0%
Grand total	4,340.4	4,421.5	5,840.4	6,130.9	4%

Chart 23. Breakdown of Transformation Line (US\$ million)⁶⁹

	2022-2023 Draft Proposed	Change from 2020-2021
Increase in country capacity and normative functions	143.2	100%
COVID-19 lessons learned	274.4	100%
Delivering on the Transformation of the Thirteenth General Programme of Work, 2019–2023	200.9	100%
– Strengthening science and research functions	32.2	100%
– Digital health strategy	147.0	100%
– WHO Academy	10.0	100%
– WHO transformation*	11.7	100%

* Document EB148/25 refers to *WHO Regional Office for Europe transformation*

There has been an improvement in budgets proposed for regions (ROs and WCOs) in the Transformation as can be seen in Chart 24.

Chart 24. Base segment of draft Programme budget 2018–2023 by major office and the WHO Academy (US\$ million)

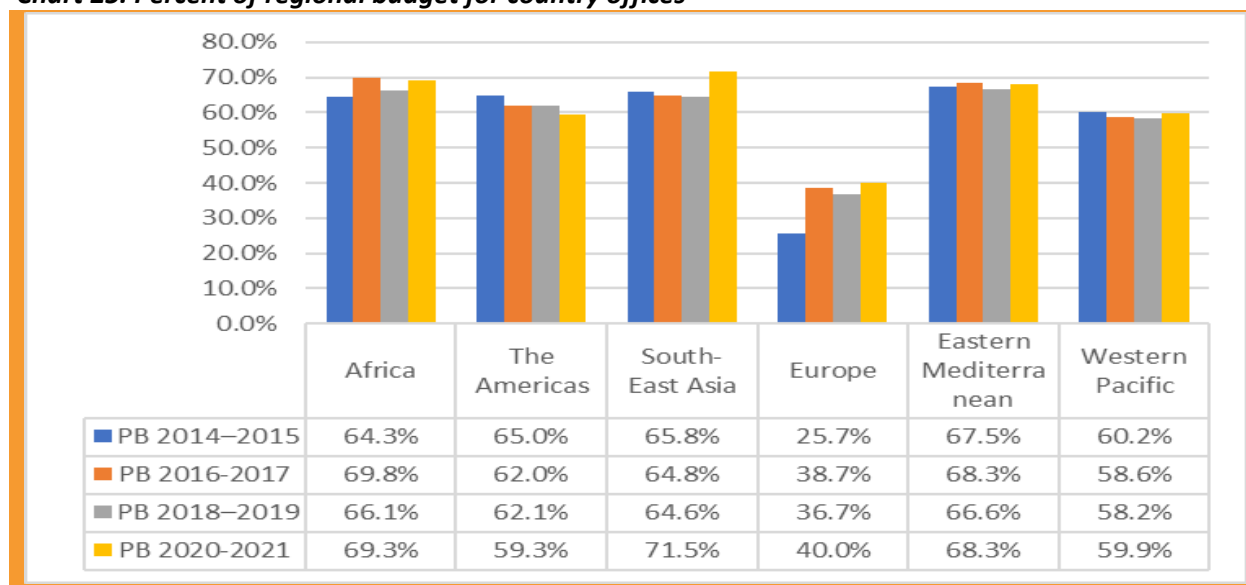
Major office and WHO Academy	2018–2019 Approved Programme budget (US\$ million)	2020–2021 Approved Programme budget (US\$ million)	2022–2023 Executive Board Draft Proposed Programme budget ⁷⁰ (US\$ million)	Change 2021 to 2022–2023	Change 2020–2021 to 2022–2023
Africa	834.1	992.4	1 180.1	19%	41%
The Americas	190.1	215.8	276.5	28%	45%
South-East Asia	288.8	388.5	429.4	11%	49%
Europe	256.4	277.9	335.4	21%	31%
Eastern Mediterranean	336.0	391.2	487.3	25%	45%
Western Pacific	281.3	309.2	363.6	18%	29%
Headquarters	1 213.6	1 193.7	1 395.1	17%	15%
WHO Academy		–	10.0	100%	100%
Grand total	3 400.3	3 768.7	4 477.5	19%	32%

⁶⁹ WHO (2020) [Draft Proposed programme budget 2022-2023 – Building forward better](#), Executive Board version (23 December 2020) (EB148/25, p. 14).

⁷⁰ Ibid, p.18.

However, the extent to which this growth has been accompanied by a corresponding reapportionment of resources to the country level has been variable from one region to the next. As Chart 25 illustrates, the proportion of resources available to WCOs has increased from pre-Transformation baseline (2014-2015) to the present (2020-2021) in some regions, while in others this proportion has remained relatively static and in yet others it has decreased over this same period. Moreover, the overall baseline level of WCO resourcing from which the regions started is highly variable as well, with some regions starting off prior to the Transformation already allocating roughly two-thirds of their budgets to country level and others only around one-third.⁷¹ Some staff members pointed out that the size of the entire budget for WHO is smaller than health expenditure of a small city in many countries, and that WHO therefore has limited potential to shift resources needed at the country level. Survey data provide mixed evidence in this regard. About 44% of staff members, who were familiar with both Transformation and country-level operations, assessed that the Transformation had improved the level of financial resources at WCOs, but 33% disagreed (corresponding numbers for the level of human resources were 48% and 36%). Interviews suggested that those staff members who had been involved in processes such as functional reviews were more likely to be disappointed in this regard as they had higher expectations for more meaningful change. Several interviewees also noted that funding and staffing had not increased commensurately with the expectations.

Chart 25. Percent of regional budget for country offices



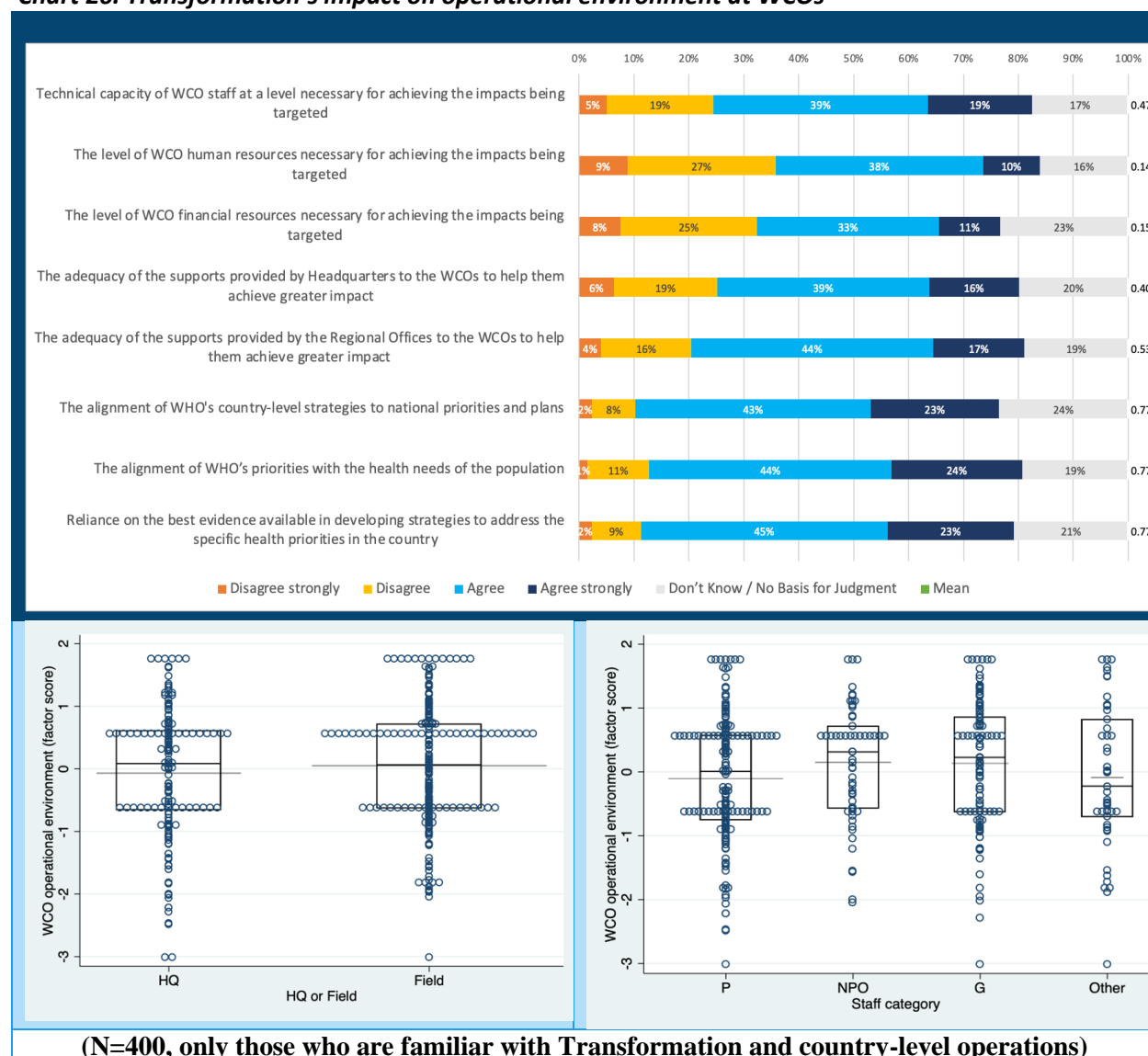
Improved operational environment for country offices

In other facets of the operational environment, staff were more positive in their assessment. These included greater alignment of WHO's country-level strategies with national priorities (66% satisfied against 10% dissatisfied) and greater alignment between WHO's priorities and health needs of population (68% against 13%). The improvement in adequacy of support provided by HQ and ROs and the use of evidence-based knowledge in formulating health priorities, similarly, received high satisfaction scores.

⁷¹ It is noted, however, that all regions do not have the same operating model.

There was essentially no difference in these perceptions by location (HQ or field) or staff category as seen in the bottom panel of Chart 26.⁷²

Chart 26. Transformation's impact on operational environment at WCOs



This positivity is also reflected in staff's assessment on how Transformation had equipped them better to deliver on WHO's agenda at the country-level (Chart 27). About 60% of the respondents agreed that Transformation was having a positive effect on achieving a range of outcomes listed in the chart and only around 20% disagreed (16% to 24% on various sub-questions). As seen in Chart 28, Member States who responded to the survey were equally positive

⁷² Note that various elements from the above Chart were combined using principal component factor scores as analysis confirmed that these elements were dimensions of a common underlying factor (WCO operational environment). Factor 1 had an Eigen value of 4.89 and no other factor had an Eigen value higher than one. All questions had factor loadings higher than 0.5 (0.71 to 0.83). Thus, it provided strong evidence for the ability of a single factor to explain transformation design. (Log-likelihood Chi-square test=1861.57, $p < 0.001$) Moreover, Cronbach's alpha was 0.91, thus providing further evidence for this to be a reliable scale for measuring transformation design at WHO.

in their assessment on issues such as alignment with the Sustainable Development Agenda, partnerships and building a collaborative culture, but were not so positive when it came to issues such as priorities- and needs-driven distribution of resources for increased country-level impacts.

Chart 27. Transformation and country-level results

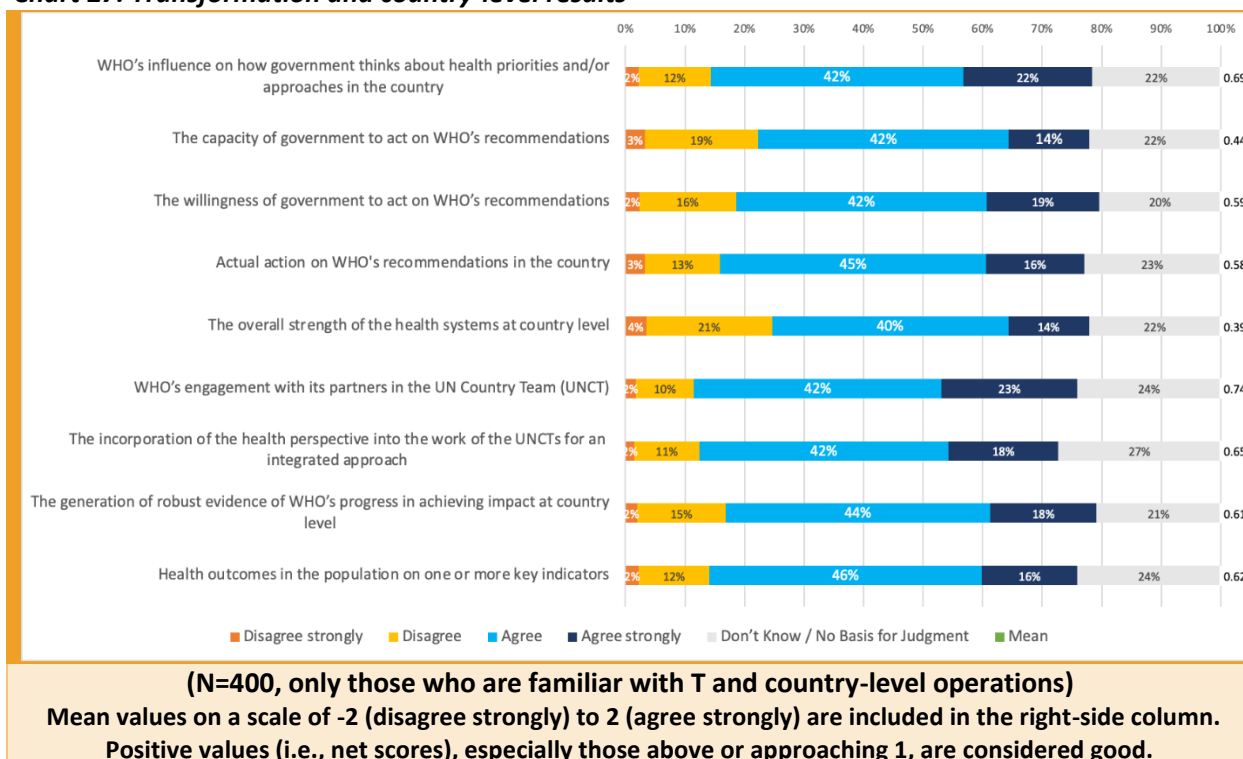
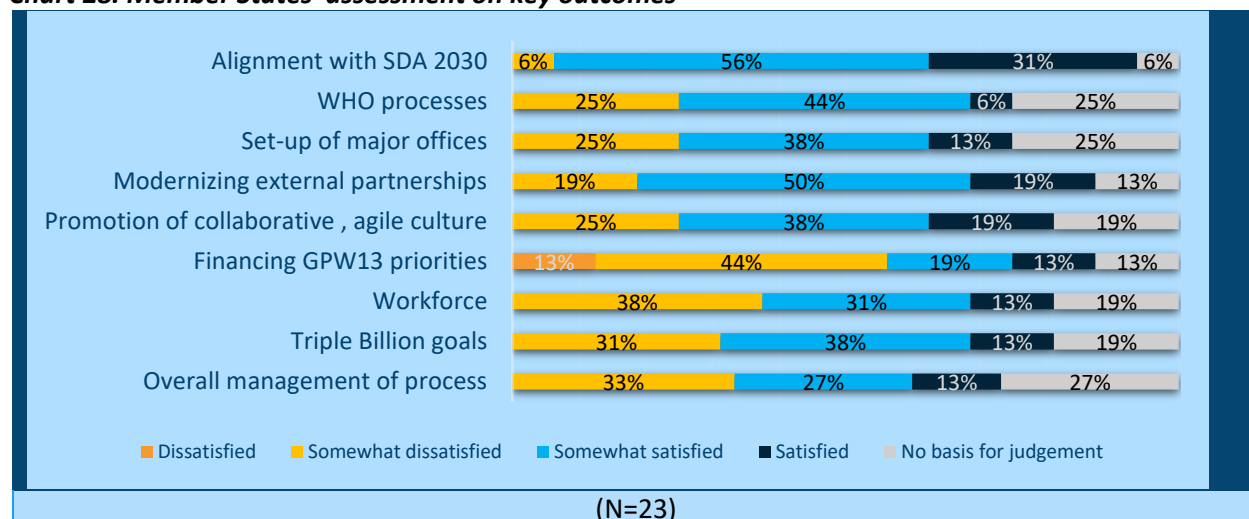


Chart 28. Member States' assessment on key outcomes



3.3.8 High-level engagement on health-related SDG agenda

This section presents findings pertaining to outcomes 3.1 to 3.3 pertaining to partnerships, alignment and accountability for the health-related SDG agenda.

The launch of the Global Action Plan for Healthy Lives and Well-being for All (coordinated by WHO but including 12 other multi-lateral agencies) in September 2019 was a positive result. There has also been a strengthening of collaboration among multilateral organizations to accelerate country progress on the health-related SDGs. This reflects the fact that WHO is better positioned to effectively shape global health decisions through transformed approaches to partnerships, communications and resource mobilization. The best evidence for which is provided by its hallmark achievements that include WHO's leadership in the adoption of the political declaration on Universal Health Coverage (UHC) at the UNGA and the Inter-Parliamentary Union Assembly, its ability to advance health on the global agenda at the G20 summit in Japan, and its role in the creation of the COVAX facility to help ensure fairer distribution of vaccines worldwide. There have also been new collaborative initiatives with GoogleFit and FIFA, which are indicative of both innovation in contributing to health outcomes and WHO's aim to extend its relevance and reach to wider populations. The new focus on innovation and the creation of the iHub, and the creation of the Science Division and position of Chief Scientist also have the potential to significantly increase the impact of WHO's work at the country-level.⁷³

COVID-19 has provided an important opportunity for WHO to step up its leadership role in the UN system at country level. In a survey conducted by CSS in the 3rd quarter of 2020, 90% of WCOs reported that their coordination role within UN Country Teams increased in the context of COVID-19. Almost two-thirds of WCOs reported that this role increased considerably.⁷⁴

By raising the head of office position at the WHO Office of the UN to the Assistant Director-General (ADG) level and appointing an ADG as the WHO Director-General's Special Representative for UN Reforms, WHO has been able to significantly increase interactions with the UN Secretariat, especially the UN Department of Operational Support, the UN Development Coordination Office, the UN Department of Global Communications, and the UN Development Programme. WHO's increased engagement has contributed to strengthening partnerships and increasing awareness of WHO's work within the UN system, as illustrated by systematic strategic engagement in six inter-agency initiatives/campaigns and hosting/co-hosting 61 high-level/advocacy events, as well as content contribution to numerous briefings for the UN Secretary-General and the UN Deputy Secretary-General.⁷⁵

A main tool at the country-level is the United Nations Sustainable Development Cooperation Frameworks (UNSDCF).⁷⁶ These are gradually replacing the UNDAFs, since 2019, and are expected to be influenced by changes in WHO's participation based on the Transformation, most notably to reflect more strongly the interdependencies of health and other sectors and addressing determinants of health in other sectors, as well as to reflect the whole-of-Organization support through the country support plans (CSP) approach. Of the 148 countries in which WHO has offices, 128 have WCOs that are organized according to the UNSDCF. WHO has representatives in each of these country teams. Of these, 53 have developed UNSDCFs since 2019, where WHO participated. Chart 29 shows the distribution by region. However, it should also be noted that country teams did not consider participation in the United Nations Country Teams (UNCTs)

⁷³ WHO (2020). [WHO Results Report - Programme Budget 2018-2019: Driving impact in every country](#) (A73/24 rev.1), 10 November 2020.

⁷⁴ WHO (2020). [The WHO Transformation: 2020 progress report](#), p.32.

⁷⁵ Ibid., p. 35.

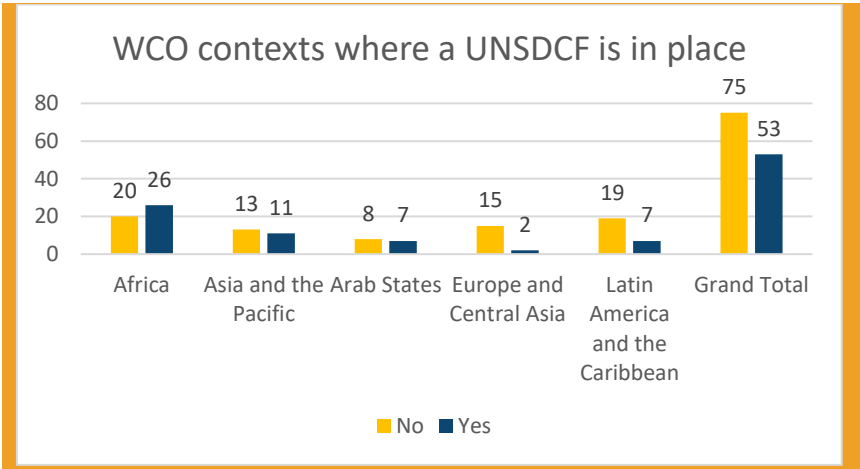
⁷⁶ Formerly, the United Nations Development Assistance Frameworks (UNDAFs).

to be a priority given all of their other tasks to be accomplished with limited resources. It was suggested that more guidance about the expected level of engagement and the linking of WR’s performance assessments with the RC system would be useful.

In terms of suggestions for improvement, one of the themes that commonly emerged during stakeholder consultations was the issue of empowering WCOs. It was suggested that Transformation had largely been a top-down approach from HQ or ROs to the WCOs. Within a broad framework developed and set up by HQ, WCO can be more empowered to develop their own innovative solutions to respond to their local needs.

Overall, DeftEdge notes that important progress has been made in improving the operational environment at the country-level, but if high expectations created by the Transformation are to be achieved, increasing resources at the country-level has to be accorded top priority going forward.

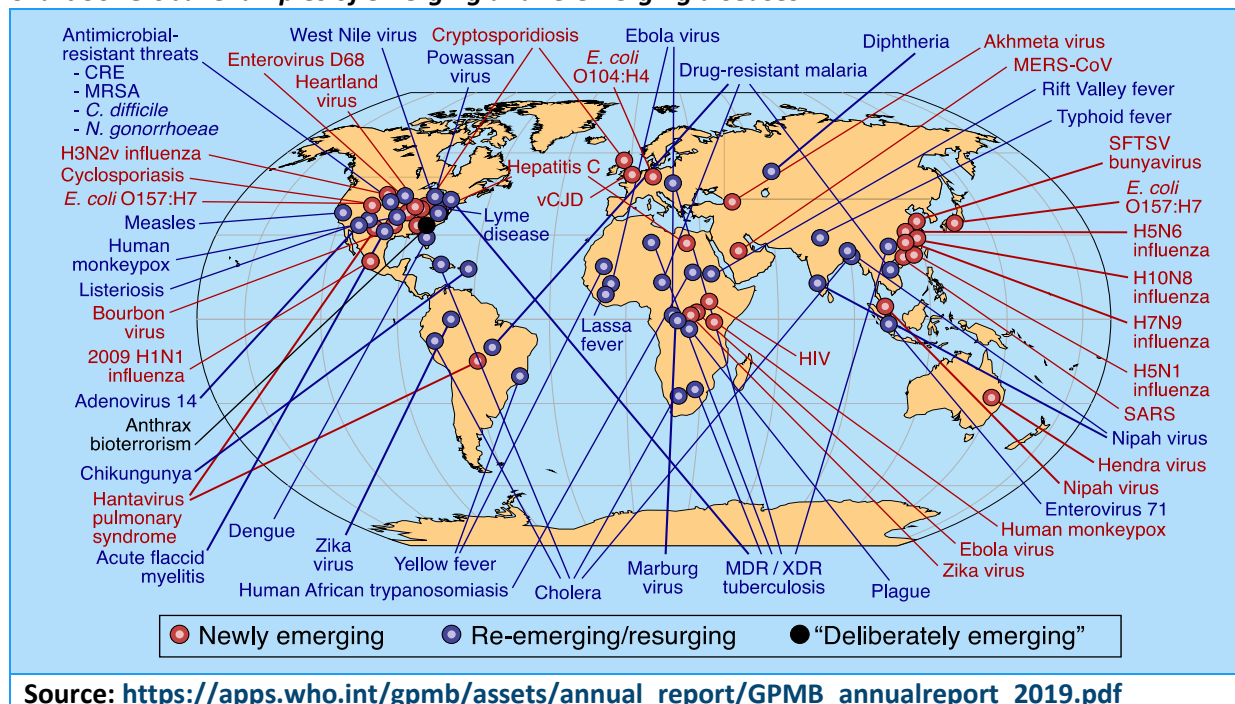
Chart 29. Reflection of WHO's work in UN's country-level agenda



3.3.9 Responsiveness in emergencies

This sections presents findings pertaining to outcomes 3.4, 3.5 and 1.3 pertaining to WHO's ability to effectively respond and support member-states' response to global health crises and emergencies.

Chart 30. Global examples of emerging and re-emerging diseases



As seen in Chart 30, WHO has had to respond to a lot of emerging and re-emerging diseases in recent years.⁷⁷ Thus, it is worth noting that the Independent Oversight and Advisory Committee (IOAC) recognizes that the WHE Programme has, over the past four years, increasingly demonstrated its ability to function effectively across the three levels of the Organization. In May 2020, the WHE Programme was responding to 174 acute events globally and a total of 60 graded crises, including five grade 3 crises and 29 grade 2 crises. WHO's response to the Ebola virus disease outbreak in the Democratic Republic of the Congo, and its management of the ongoing serious health emergencies in Yemen and Syria and the Rohingya crisis in Bangladesh have in many respects been a proof-of-concept test for the WHE Programme. According to the MOPAN Report, within 24 hours following the announcement of an Ebola virus disease (EVD) outbreak in the Democratic Republic of the Congo (DRC) on 5 May 2018, the WHE Programme activated a full Incident Management System at global and regional levels. Within days, WHO deployed more than 50 experts, released contingency funds, contacted key partners, notified the UN Secretary-General and sent a team to the field site immediately after the confirmation of two cases in the country's Equateur Province. The response was swift and had shown improvements from the 2013 Liberia outbreak.

⁷⁷ Similarly, Chart A12 shows the challenges in managing complex global architecture on managing health emergencies as well as predicted losses from such emergencies. This chart provides a stark reminder of the degree of challenge confronting WHO and why its Transformation must succeed for the sake of achieving SDGs.

However, the international spread of COVID-19 has highlighted the challenges of handling a global pandemic and has tested WHO as never before,⁷⁸ and the Independent Panel for Pandemic Preparedness and Response, in its interim findings, has found that the global pandemic alert system is not fit for purpose: “critical elements of the system are slow, cumbersome and indecisive.”⁷⁹ The International Health Regulations (2005) (IHR)⁸⁰ are a legally binding international agreement between 196 States Parties, including all WHO Member States, to work together for global health security. Through the IHR, countries have agreed to build their capacities to detect, assess and report public health events. The Independent Panel found the procedures and protocols attached to the operation of the IHR, including those leading up to the declaration of a public health emergency of international concern, need to be brought into the digital age. Noting the critical role of Member States in data reporting, the IOAC recommended in its interim report to the WHE Programme that the WHO Secretariat further streamline the reporting process and support countries in strengthening capacity to report on the information required under the IHR.

Under the Transformation, WHO implemented a number of technical and business processes to bolster WHO’s efficient and evidence-based response to emerging strategic issues and global health emergencies.

As noted in the ACT-Accelerator Prioritized Strategy & Budget for 2021:⁸¹

“As the United Nations agency specializing in global health, the **World Health Organization** provides global leadership in the monitoring and reporting on health security threats including the COVID-19 pandemic, sets norms and standards, and issues technical guidance on all areas of public health. WHO collaborates with scientists and policy makers on a global scale to drive the R&D agenda for COVID-19 tools and develops standards on the manufacturing, testing and regulatory oversight of products developed. WHO’s 150 country offices and close working partnerships (with Ministries of Health, other UN agencies including UNICEF and development partners such as the World Bank) enables the provision of technical assistance ‘on the ground’ to support country readiness and build capacities.”

COVID-19 had both positive and negative implications for the Transformation. As noted earlier, COVID-19 has delayed implementation of human resource management changes such as those pertaining to performance evaluation and field mobility. However, it has also hastened improvements. For example, the WHE Programme established the COVID-19 Supply Chain Inter-Agency Coordination Cell, composed of staff from WHO, the United Nations Office for the Coordination of Humanitarian Affairs and the United Nations World Food Programme, to help respond to the COVID-19 pandemic. While supply chain management was one of the redesigned processes, thanks to the COVID-19 there has been a greater attention to this aspect. It was noted in interviews that in some regions, like the Americas, this has been in place for some time, but this is now spreading to other regions.

WHO has significantly scaled up its resource mobilization capacity in response to the COVID-19 pandemic, and in 2020, it had one of its most successful fund-raising efforts. This is also reflected in the [Access to COVID-19 Tools \(ACT\) Accelerator](#), launched in April 2020, as a global solution for expediting the end of the COVID-19 pandemic. In September 2020 it announced a goal of obtaining US\$ 38.1 billion to address the pandemic.⁸² ACT is structured according to three pillars, a connector and a workstream. These are as follows, and as can be seen, WHO is a major partner in several as well as the lead in COVAX:

⁷⁸ [Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme, Interim report on WHO’s response to COVID-19, January-April 2020.](#)

⁷⁹ Second report on progress by [The Independent Panel for Pandemic Preparedness & Response](#), January 2021.

⁸⁰ [World Health Organization, International Health Regulations \(2005\), Third Edition, WHO, 2005](#)

⁸¹ WHO (2021). [ACT-Accelerator Prioritized Strategy & Budget for 2021](#), p.39.

⁸² Ibid.

- The **Vaccines Pillar**, also known as **COVAX**, is co-convened by the Coalition for Epidemic Preparedness Innovations (CEPI), Gavi, the Vaccine Alliance, and WHO, with UNICEF as a key delivery partner.
- The **Diagnostics Pillar** is co-convened by the Foundation for Innovative New Diagnostics (FIND) and the Global Fund, with WHO leading on regulatory, policy, product procurement and allocation, and country access and support, while supporting R&D efforts.
- The **Therapeutics Pillar** is co-convened by Unitaid and the Wellcome Trust, with WHO leading on policy and regulatory work, and the Global Fund leading work on procurement and deployment.
- The **Health Systems Connector** is co-convened by the Global Fund, the World Bank and WHO, with support from The Global Financing Facility for Women, Children and Adolescents (GFF).
- The **Access & Allocation** workstream is led by WHO and directs ACT-Accelerator's work on global equitable access and allocation

In 2020, WHO also launched the Rapid Review Group to provide rapid evidence retrieval and analysis in support of key questions necessary for creation of WHO's normative guidance in emergencies; implemented a new Global Public Health Goods (GPHG) planning review process and rolled out quality assurance of GPHG principles, criteria and checklist; and launched a new publications clearance process and established a Publications Review Committee for COVID-related publications. The harmonization of processes for developing norms and standards was intended to promote a more agile, innovative and responsive culture, however there is little evidence from the evaluation that this is the case. WCO and RO staff had noted high hopes for streamlined norms and standards and publishing processes, which currently vary by region, and that it would help technical officers produce and publish technical work in an efficient way and increase relevance at the country-level. However, interviewed staff noted decreases in publications and notable timelines to bring a report from concept to publication. They remarked the publication process needed to improve. This was considered significant for a technical agency that had many reports in the pipeline. Stakeholders remarked that it would be a challenge to clear the pipeline over six months to a year, by which time it would not be relevant anymore.

The hiring of a Chief Scientist and establishment of the Innovation Unit were noted as positive outcomes of the Transformation, increasing the Organization's ability to become more agile and responsive to countries' strategic issues and global health emergencies. The innovation process is currently being piloted on specific clusters of innovations (e.g., in women's and children's health, medical oxygen, nutrition and others). Some WHO staff noted a change in mindset and outlook with the Innovation Unit in place, highlighting how it has brought new ideas to the table and serves as a catalyst for innovation within the Organization. However, it was also expressed that innovation still needs to be fully implemented. According to interviews, innovation is more prominent at HQ and regional levels, and is lacking at country level. Overall, it is believed that innovation, establishment of new divisions, engaging staff in leadership initiatives such as the LEAD initiative is the way towards an agile and effective WHO.

Much of the success of the Transformation will ultimately depend on the capacity of Country Offices to further support health outcomes. RDs and WRs reported that WHO's higher profile as a result of the pandemic has led to increased interactions with governments beyond the Ministries of Health. Discussions are now also being held with policy makers in ministries of planning and finance, among others. Maintaining these broader relationships is seen as critical to achieving the triple billion goals as many issues extend beyond the scope of the health ministries. This opportunity for extended relationships highlights the need for well resourced WCOs led by highly capable and empowered WRs who are equipped

with skills for multisectoral work as well for management, advocacy, communication and resource mobilization.

Interviewees noted that the increasing expectations on WRs needs to be met with further investments in their training and ongoing support,⁸³ such as that provided through UNICEF's onboarding process. UNICEF not only has a rigorous selection process, it also provides management and leadership training, external professional coaching, 1:1 mentoring with a seasoned country representatives, and a peer network. Furthermore, those selected and in the queue for placements are provided with further training to help ensure that they are ready to take on the role at any time. Interviewees also suggested that WHO's selection process for WRs needs to be tightened to ensure that high standards of assessment centers are maintained. Although ROs and WHO's Country Support team play an important role in connecting and supporting WRs, further downstream investments were noted as being critical.

Chart 31. Member States' feedback at a glance

As described in the Methodology section, Member State feedback on the Transformation was sought through focus group discussions, a questionnaire, and individual one-on-one interviews for those who wished to avail themselves of this option. (Annex XI contains a synthesis of the feedback obtained through the questionnaire and focus group discussions.) Across these various modalities the feedback provided was highly consistent among Member States participating in the evaluation, namely strong support for the Transformation initiative and strong understanding of its overall objective – coupled with equally strong concerns over a lack of clarity in the initiative's subsequent rollout, about their own lack of knowledge surrounding the effectiveness of the Transformation in achieving concrete results to date or on the way forward, and about the Secretariat's engagement with them in a way that would help ease these other concerns.

Sentiment surrounding the overarching need for the Transformation was generally positive: Member States voiced their support for the initiative as a means of repositioning the Organization for greater impact. Several Member States pointed to the GPW 13 itself as a significant accomplishment in its own right as a vehicle for clearly articulating the end objectives being sought – the triple billion goals – as well as the broad contours of the changes that would be required to achieve these objectives by way of the Transformation. Many also mentioned specific initiatives within the Transformation that they felt to be particularly significant and positive, e.g., improvements to the programme budget, the creation of the Science Division and the role of the Chief Scientist; restructuring of the Organization, improvements to the functioning of the WHE Programme; the WHO Academy concept; and the commitment to address issues of gender, equity and human rights.

Beyond this broad support for, and understanding of, the Transformation and some of its specific components, Member States consistently express a lack of clarity surrounding key aspects of the Transformation. Areas lacking clarity range from fundamental aspects of the initiative – e.g., what initiatives within WHO do and do not fall under the Transformation, how the various activities within and between workstreams are intended to work together in a complementary way to achieve the end objective, the extent to which planned initiatives are truly on track against a clear and time-bound plan (as opposed to a list of activities and outputs, unbound by a set target or timeline, being presented) – to specific issues around the finalization of the WHO structure, the creation of senior-level positions at HQ and the connection of these additions to the Transformation, and the extent to which the Transformation is achieving real change within the Organization and impact at country level. In light of these shortcomings, some Member States express unhappiness over being asked to pay for the Transformation without being provided a sufficiently clear picture of what they are paying for.

Underlying this lack of clarity is a sentiment, conveyed strongly and consistently by Member States, that they have been insufficiently engaged by the Secretariat throughout the rollout. Most interaction, they report, has been in the form of updates provided on the official agenda of governing body meetings and through the associated progress report documents. Some underscore the sentiment that more deliberate, open and transparent engagement through other consultation avenues would help foster greater understanding of, and support for, the initiative which has not been as clear or transparent as they would like.

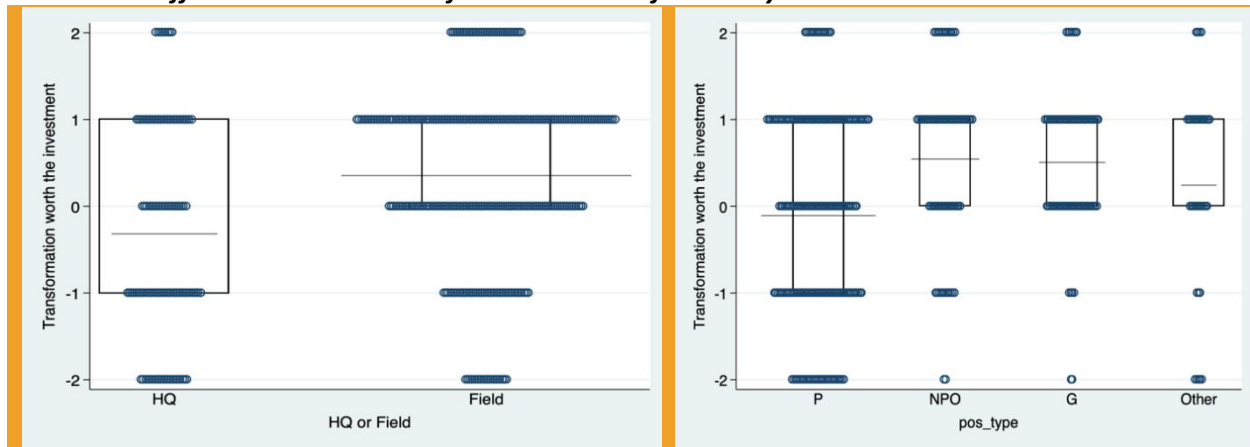
Despite these concerns, support for the Transformation and its end objectives remains strong. Moving forward, however, Member States envision a relationship of greater and better engagement with the Secretariat. Their other main concern in the final phase of the Transformation is of a practical nature: the need to ensure, as a matter of priority, that the challenge of adequately resourcing WCOs is resolved if the initiative's end goal of enabling impact at country level is to be achieved.

⁸³ This work is under way, as evidenced in the scaling up of the leadership training initiative of the Regional Office for Africa and the establishment of the Global Mentorship Programme.

3.3.10 Value-for-money: Has Transformation been worth it?

Finally, some questions were raised throughout the data collection process concerning the value-for-money in designing Transformation. A significant amount of resources, including about ten million dollars in direct payment to consulting companies on top of staff time, have been invested in the process, although no financial records are available in one central location to quantify the exact amount spent on the Transformation so far. Staff, in both survey (Chart 32) and interviews raised questions. HQ staff, in particular, were more likely to be skeptical about the value-for-money from this initiative.

Chart 32. Staff assessment on Transformation value-for-money



However, it is too early in the process for the evaluation to make a determination in this regard. To demonstrate its value, WHO will need to establish outcome indicators and milestones specific to Transformation. As of now, the only finding in this respect that can be derived pertains to the formulation of GPW 13, which was decidedly found to be superior, by most stakeholders, than GPW 12. The other potential significant positive outcome at this stage pertains to a positive shift in organizational culture, which may result in WHO becoming a more collaborative, less hierarchical and more agile Organization. If WHO addresses the issues raised in this evaluation, such as alignment of resources in line with the goals outlined in GPW 13, and provides stronger incentives for change (coupled with disincentives for a lack of change), it would likely be worth far more than the investment. A judgment in this respect would need to be made at the next evaluation of the Transformation.

4. CONCLUSION AND WAY FORWARD

Despite the constraints imposed by COVID-19, WHO has made a significant progress in implementing its Transformation. This is especially true in terms of strategic alignment between GPW 13 and organizational structure and design, which has established a solid framework for strategic transformation of WHO. There are also areas, like finance and human resources where the basis for improvement has been established but more work needs to be done to implement the Agenda. However, despite recognizing the criticality of resource alignment to achieving strategic goals — the Transformation plan notes that, *“Under-resourcing a reform effort is one of the most common drivers of failure”* — resource alignment to a significant degree has not yet been initiated. As WHO seeks to increase its contribution to country-level impacts, Transformation in its next phase should shift its focus towards transforming WHO’s footprint in countries of focus (which is one of the stated objectives of Transformation).⁸⁴

The evaluation, based on its extensive data collection, robust analysis and triangulated findings provides an overview of progress and avenues for moving forward. See Chart 33, which using excerpts from the Transformation Theory of Change, provides an overview at a glance.

Overview: A lot of energy went into envisioning and designing WHO Transformation. By spending a lot of effort upfront, WHO has positioned itself to succeed in realizing its Transformation goals. As hard as it has been, as can be seen from the dark blue regions on Chart 33, it is only the start of an arduous process aimed at achieving a lasting change. This section provides concluding remarks on Transformation’s achievements, shortcomings, missed opportunities and challenges ahead.

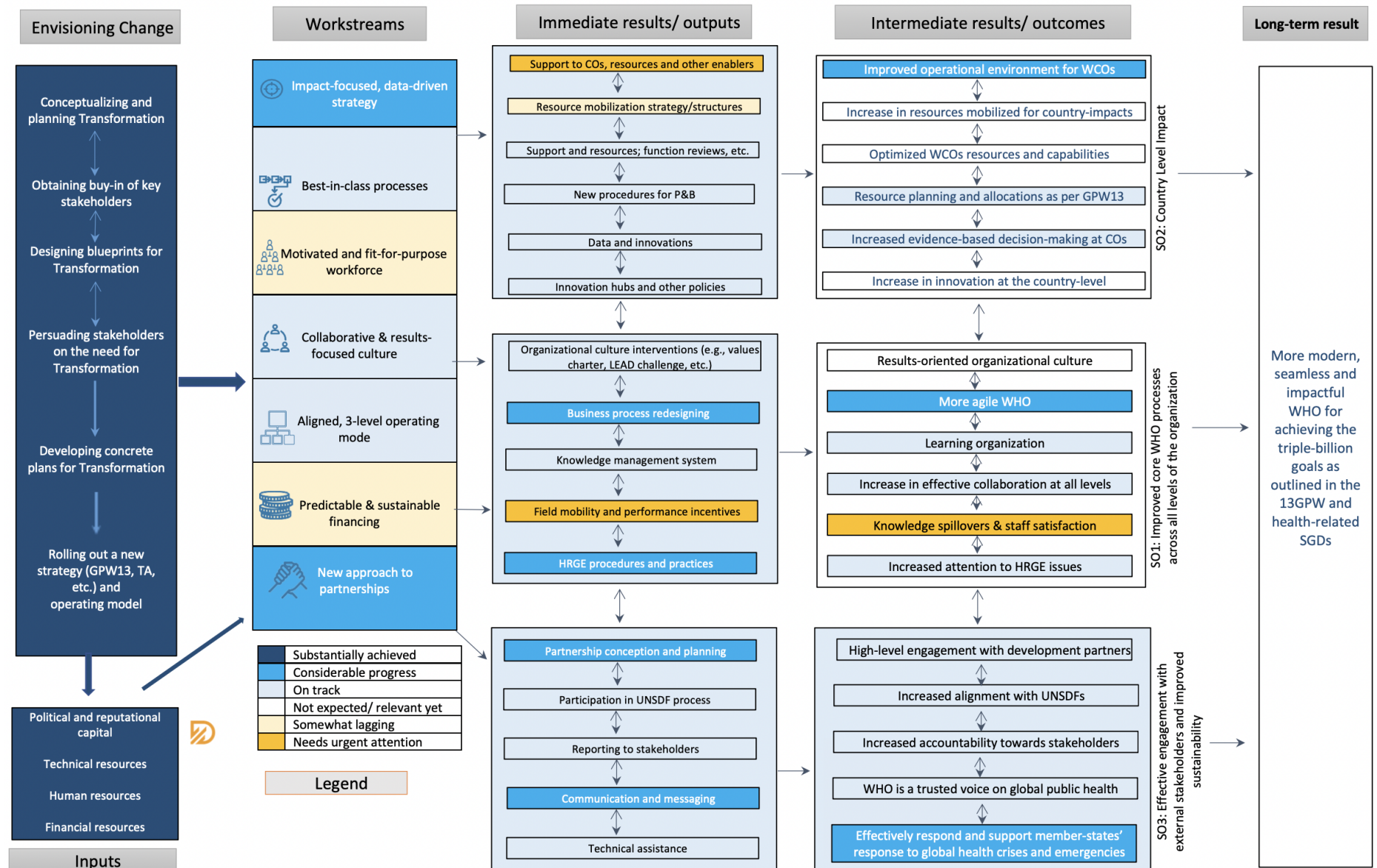
During the Transformation design stage, a good deal of effort was made to learn from the past, engage staff in the process, and repurpose the Organization for the future. It has also been an ambitious undertaking, and significant progress has been made in most of the work streams. And progress has continued despite COVID-19; in fact, in some important ways, the pandemic has served as both a test case and a proof of concept that the Organization can work more nimbly and effectively under unprecedented constraints. Moreover, the COVID-19 response, while serving as a positive testing ground for many of the reforms, has consumed a large proportion of the Organization’s attention span and energy, thus forestalling some important aspects of the change.

Most of the work so far has been focused on strategic realignment and its effect has been felt most notably in the design of GPW 13. However, real work of resource alignment to implement GPW 13 towards achievement of country-level result is yet to begin.

In terms of missed opportunities, not adequately engaging Member States in the design of Transformation stands out the most. By regarding the Transformation primarily as an internal change management process, WHO has missed a critical opportunity to engage with – and gain the goodwill of -- the Member States, especially since WHO is a member state organization. Moving forward, closer, better, more regular and more transparent communication with Member States on the Transformation will be necessary if WHO is ultimately to attain its desired objective of becoming a modern fit-for-purpose Organization that is optimally placed to achieve – and demonstrate – greater impact at country level.

⁸⁴ WHO (2021). [WHO transformation – Transforming for enhanced country impact](#) (EB 148/32), 4 January 2021.

Chart 33. Transformation progress and achievements at a glance



More detailed conclusions are provided next.

Design: The Transformation design, within the context of broader UN reforms, was developed taking into account evaluations of previous efforts at reform in the WHO that had been ongoing since 2011. Of particular importance was the mid-term evaluation of the transformation undertaken by the African Region starting in 2015. The process involved considerable participation of staff in the design, which was reflected at the strategic level in the very ambitious Global Programme of Work 2019-2023 that fundamentally seeks to re-organize and focus the Organization on triple billion goals and health-related SDGs. Approved by Member States early in the process, it formed the basis for the programme budget for 2020-2021 that specified how resources were to be used to achieve specific objectives, and which would be reported in a results-based way. The Transformation included a significant re-organization at HQ with a view to replacing traditional silos with more comprehensive units that could more effectively support WCOs. One example was the creation of a Science Department incorporating all research and led by a Chief Scientist, and the establishment of a WHO Academy to consolidate knowledge and experience, and pass it on to staff and others.

The extent of staff involvement was unprecedented for a reform in an international organization and included a range of in-person and virtual consultations organized by the Transformation Team. This provided the basis for staff support of the reform. However, like all large reforms there were also issues relating to changes that were made by re-organization and many staff found these to be problematic, especially at HQ. In contrast, in the African Region, where an effort was made to continually engage WCOs with the RO, satisfaction was relatively high. This Region had also had a headstart as the Transformation there had started earlier. Some of the reforms were affected by COVID-19, which altered how WHO functioned in several ways, and delays were also experienced with respect to financial and human resource reforms.

Unlike earlier reforms, the Transformation was mostly seen as an internal exercise rather than one that needed to involve Member States. Member States were engaged to a much lesser degree than in previous reform efforts and the Transformation did not address issues of governance. There was some dissatisfaction with the lack of consultation, although the preparation of the new programme budget for 2022-2023 provided an opportunity for consultation with the Member States towards overcoming this shortcoming.

The design of the Transformation remains relevant. It was focused on change processes, but did not include a robust theory of change or logic model that looked at linkages between components and clearly articulated a measurable end state. As a result, there has been some uncertainty about whether and when the Transformation will end, what the markers will be, and the metrics to measure success.

Status of Implementation: The roll out of the transformation is behind what was initially envisioned. The most recent reporting shows that about half of all initiatives are fully implemented. However, given the unique structure and characteristics of WHO, the scope of the Agenda, the interdependencies of many of its systems, and the pandemic response, progress has been substantial. Hence, there is a general consensus that WHO is making some progress towards its Transformation goals.

Gains have continued to be made, even during the past year, on the forty initiatives within the seven workstreams. Of these, external partnerships and building a results-focused culture are the closest to achieving the structure, systems and processes that would help to achieve country impact. Several business processes and human resource initiatives have lagged but movement should be more apparent

in the next quarter, including on contracting a provider for the new ERP system and with reducing recruitment backlogs. The initiative where the least progress is evident is the Motivated and Fit-for purpose Workforce workstream. Overall, significant work remains to be done, including further refinement of processes such as the Output Scorecard, and reviews of the extent that newly introduced processes are actually more effective and efficient. There is also a need to be mindful of the volume of initiatives and requests from HQ and the capacities of regions and countries to respond and absorb, particularly with the ERP rollout.

The formal designation and staffing of the Transformation Implementation and Change Office is important for rebuilding the momentum of the Transformation post-pandemic and sustaining and solidifying progress made. It demonstrates significant organizational commitment to providing continued support to business owners, tracking progress, as well as continuous improvement and learning.

Effectiveness: As noted earlier, WHO is making substantial progress towards its Transformation goals. There has been success in strategic planning reflected in the GPW 13 and in the current programme budget. Additionally, results-based management has been built into the process of reviewing the strategies, moving from an original focus on outputs to one that emphasizes outcomes. There is considerable evidence that there has been a small and positive, but statistically significant, change in the Organization's culture, particularly with respect to staff perceptions on being heard and valued. If further reinforced through incentives, this may provide the basis for a more collaborative and less hierarchical culture at WHO. Needless to add, as cultural changes take a long-time and sustained efforts, WHO will need to continue building on this momentum.

There is also some progress, necessitated by the pandemic to an extent, on flexible working conditions and results-orientation of staff. This is also reflected in the WHO Values Charter introduced in 2019. However, realignment of human and financial resources, including staff mobility to increase country-level impacts and forge one-WHO, has been delayed. This would need to be a top priority going forward.

With regard to sustainable funding for the Organization, the next proposed programme budget may deliver some progress as a result of both Transformation in GPW 13 and the consequences of COVID-19. WHO has also initiated a number of other initiatives to find new sources of funding, including from the private sector via the new WHO Foundation, as well as through early efforts to encourage WCOs to look for additional funding directly. This, however, will require further reforms of internal and external systems. One of these is WHO participation in the UN System at the country-level. The evaluation concludes that WHO is becoming a larger player in UN country teams, a role that has been expanded in the context of COVID-19 where WHO has been a leader. It is also reflected in the upgrade of the head of the New York office to ADG level. However, to address the chronic underfunding of WHO requires a more comprehensive approach, one that has funding linked to the country-level impacts as per the triple billion goals. Initial steps to manage finance better need to be followed up in the next biennium, with the ongoing reform of sustainable finance at the Member State level being part of this.

The changes in administrative procedures such as digitization of approval mechanisms, communication via digital platforms, and use of technology generally have contributed to some key results such as strengthening internal and external communications and increasing organizational alignment across all levels. However, for the most part, the centralization of key processes has not yet realized efficiencies, with the onset of COVID-19 also imposing change, either delaying some process re-design and implementation timelines or pushing forward outcomes on others. There are also questions about

whether the centralized systems and harmonized processes, such as recruitment, knowledge management through the WHO Academy, and norms and standards will reach countries, or add additional layers of bureaucracy.

Data and responsiveness: WCOs felt that data systems have put in place the building blocks for data-driven decision-making, and that ultimately, tools like the Triple Billion Dashboard will be helpful for HQ to gather up-to-date statistics on diseases and deaths globally and provide relevant guidance to WCOs based on trends and lessons, which was seen by HQ as an unfulfilled core mandate of WHO. Processes are now in place, which may make data collection and processing a bit easier through the online platform, but there has been inadequate training experienced at the country level to fully realize the power of the available data for driving programming towards country impact. Noting the critical role of Member States in data reporting, the WHO Secretariat may need to further streamline the reporting process and support countries in strengthening their capacity to report on the information required under the IHR.

Country-level Capacity: Meeting the Transformation's country-focus goals and taking advantage of WHO's current increased profile at the country level requires highly competent and empowered WRs. This requires WRs who are strong leaders and managers, who are also equipped with skills for multisectoral work as well for management, advocacy, communication and resource mobilization. Although the ROs and CSS play an important and appreciated role in assisting and connecting selected WRs, consideration should be given to further investments in training, coaching and mentoring such as that provided by UNICEF. WHO's selection process for WRs needs to be strengthened to ensure that high standards are maintained within the assessment process. The pandemic has increased the stature of WHO at the country level with RDs and WRs reporting increased interactions with governments beyond the Ministry of Health, and this momentum needs to be maintained.

HRGE: Gender equity and diversity are increasingly reflected in staff structures at various levels (HQ/ROs/WCOs), however, there are still gaps in higher grade positions (P4, D1, D2) and variations across regions, and gender and human rights considerations have not been reflected in management practices, processes, and promotions to the same extent. Although there has been notable progress in the hiring or mobility of women in certain positions as a result of the DG's example through his appointments, and new opportunities presented for participation in decision-making processes through the G-Force and 'open door policy', the shift to being a more inclusive culture is not yet felt throughout the Organization. The creation of new career progression opportunities for NPOs and collection of disaggregated data, however, are positive steps in this direction.

Based on the findings and conclusions, the evaluation makes a series of recommendations, in the next chapter, to improve the effectiveness of Transformation, and therefore the functioning of WHO.

The recommendations that follow seek to capitalize on the enabling factors that have facilitated progress to date and address those factors that have hindered further progress thus far. The draft recommendations were shared with the ERG and their input has been considered in this final version of the report.

5. RECOMMENDATIONS

The evaluation makes five recommendations that aim to address the areas for improvement outlined in the report and, in keeping with the formative focus of the evaluation, these recommendations aim to enable the full and consistent implementation of the WHO Transformation moving forward. Roughly structured according in their order of criticality, these are as follows.

Recommendation 1: The WHO Secretariat should establish clear and comprehensive outcome-level milestones for the remainder of WHO transformation and use these measures as an internal management tool and as a communications tool for reporting on progress.

Building on the inferred theory of change developed for this evaluation, the WHO Secretariat should:

- a. Revise this theory of change, as necessary, to make it as comprehensive and meaningful an encapsulation as possible of the results road map for transformation – that is, the desired end state sought by the initiative, how the various workstream initiatives are intended to contribute to each outcome both individually and jointly, the inputs (human and financial resources, partnerships), and the assumptions and risks to be managed in the final stage of transformation;
- b. Operationalize the theory of change in a series of specific, measurable, actionable and attainable, relevant, and time-bound (SMART) outcome-level milestones (that is, key performance indicators), accompanied by corresponding timeline milestones for when it is expected that targeted outcome-level changes will be fully realized, bearing in mind the assumptions identified in the theory of change;
- c. Aim to maintain a record of the human and financial resources expended on transformation throughout the Organization so that there is a clearer picture of the organizational investment in the initiative; and
- d. Use the theory of change and accompanying metrics to monitor and report on progress moving forward.

Recommendation 2: The WHO Secretariat needs to engage its Member States better throughout the remainder of WHO transformation's implementation.

In this regard, priority should be placed on:

- a. Clearly and transparently communicating the results roadmap encapsulated in the theory of change, including what organizational initiatives are and are not directly part of the transformation;
- b. Regularly providing Member States with clear updates on progress made (including progress not made) against the implementation plan as well as targeted outcome-level changes;
- c. Consulting with Member States, as appropriate, on any ongoing or new/emerging Transformation-related initiatives.

Recommendation 3: Without losing momentum for continued progress at all levels of the Organization, the WHO Secretariat should invest dedicated attention – and resources – towards supporting country-level transformation in the next phase.

With emphasis having thus far been on changing operations at headquarters and, in some cases, regional offices, in the next phase attention must redouble its focus on the end goal of this organizational change initiative and the GPG's vision of a strengthened WHO country presence: transforming country offices and transforming supports to country offices in order to realize WHO's vision for country-level impact. Towards this end, the WHO Secretariat should prioritize the following measures:

- a. The Programme budget 2022-2023 should allocate adequate resources to country-level operations and, once this is approved, WHO country offices should be encouraged to better apportion their resources towards making larger country-level impacts and fully realize the GPG aspirations for the WHO country-level presence and operating model.
- b. Specific targets should be established for the number of positions increased (moved or newly created) in country offices.
- c. Further investments in the WHO Representative selection and development process should be made in order to ensure strong competencies in leadership, management, advocacy, resource mobilization and multi-sectoral partnership work.
- d. Based on the finalized theory of change for WHO transformation, any additional measures that are necessary for improving transformation at country level and the supports for country-level impact from other corners of the Organization should be identified and pursued.

Recommendation 4: Efforts should be intensified to build a motivated and fit-for-purpose workforce.

As a crucial means of advancing multiple goals conducive to the success of transformation – for example circulating knowledge across the three levels of the Organization, forging a “One WHO” identity within its organizational culture, fostering a heightened sense of how country offices operate and what supports they need in order to enable their work, and cultivating a motivated and fit-for-purpose workforce, the WHO Secretariat should:

- a. prioritize implementation of the reforms in human resources, including the development of WHO career pathways, enhancing contracting modalities and the implementation of global geographic mobility; and
- b. to promote staff mobility and rotation, when filling all new positions or replacement vacancies, consider if the position in question can be located at decentralized level without the loss of overall organizational effectiveness to WHO. Hiring managers should either move the position to the field or explain why it should not be moved to the field, in keeping with the “comply-or-explain” principle.

Recommendation 5: The WHO Secretariat should accelerate the pace of desired changes in its organizational culture.

The WHO Secretariat should consider the following actions to accelerate and embed desired cultural shifts throughout the Organization:

- a. Building on initiatives such as the WHO Academy and the leadership training initiative of the Regional Office for Africa the WHO Secretariat should escalate its investment in leadership and professional skills development at all levels of the Organization, but especially among WHO representatives and managers elsewhere. Leadership initiatives should incorporate the cross-cutting priorities of gender equity and empowerment and diversity and inclusion.
- b. Actions such as the Director-General's open-door policy should not only be modelled at the top but also promoted by managers at all levels of the Organization. Regular feedback, including by documenting and responding to relevant proposals submitted by staff, should be considered a central element of this strategy.
- c. A more concerted effort needs to be made to align policies and procedures with the new norms of collaboration and agile functioning.