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Selected Corporate and Decentralized evaluations

Findings, recommendations, actions and learning

WHO Evaluation Office

World Health Organization

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1.0 Introduction

1.1. This document provides details of the actions taken by the Secretariat in response to recommendations from selected evaluations conducted during the period 2011-2015. The Evaluation Office has specific responsibilities with regard to tracking the management response to high-level evaluations. The selection of the corporate and decentralized programme evaluations was based on criteria that related to organizational relevance, significance and utility.

1.2. The Evaluation Office developed a management response template to track the implementation of recommendations from the evaluations. This template includes the recommendations copied verbatim from each evaluation report and details of the management response and the status of implementation as at 31 March 2016. The template draws on best practice from other UN agencies' evaluation tracking mechanisms. It was sent to the responsible managers and senior staff involved in the evaluations; their responses to the template are included in this document. Additional questions were also asked to provide information about the context, background and findings of the evaluation. Where necessary, the Evaluation Office gave guidance to the responsible unit on how to complete the template.

1.3. The management responses to the specific recommendations were assessed as follows : (i) Accepted (ii) Partially Accepted ; (iii) Not Accepted ; or (iv) Other. The status of the management response was also tracked and categorized as either : (i) Not started ; (ii) In progress ; or (iii) Implemented. In cases where recommendations were not accepted, this was primarily due to a lack of funding or organizational changes that rendered the original recommendation no longer applicable.

1.4. The evaluation findings and recommendations highlighted should contribute toward improved performance and increased accountability for results. The management responses should also inform key decision-making and future programme and project development, especially where the recommendations have been incorporated more broadly in wider policies and plans or have influenced departmental strategy.

2.0 Detailed information on the status of recent evaluations

2.1. Quick Start Programme of the Strategic Approach to International Chemicals Management: progress and challenges towards the achievement of the Goal for 2020 (2015)

2.1.1. This external impact evaluation was commissioned by the Executive Board of the Quick Start Programme of the Strategic Approach to International Chemicals Management (SAICM) in 2014. SAICM is a policy framework to promote chemical safety around the world and is administered by UNEP. Its overall objective is the sound management of chemicals and hazardous wastes throughout their life cycle so that, by 2020, chemicals are produced and used in ways that minimize significant adverse impacts on human health and the environment (the "2020 goal"). The objective of the time-limited Quick Start Programme, which is now coming to an end, is to support attaining initial enabling capacity-building and implementation activities to support the 2020 goal in a range of vulnerable target countries. The final evaluation report was submitted to the International Conference on Chemicals Management at its fourth session (Geneva, 28 September-2 October 2015).

2.1.2. Based on an assessment of 158 projects funded by the Quick Start Programme Trust Fund, the evaluation concluded that projects largely completed activities across all major activity types with success. These projects sought to achieve one or more of three outputs: (i) a national SAICM implementation plan developed; (ii) a national governance structure agreed; and (iii) raised awareness and exchange of information. The report provided eight recommendations for the further development of the Quick Start Programme.

2.1.3. The recommendations of this evaluation were directed at the SAICM Secretariat in UNEP, which is responsible for the implementation of the programme. WHO is one of a number of organizations that have been executing agencies for Quick Start Programme projects. Some of the recommendations are therefore applicable to WHO, where they concern project implementation. WHO still has one ongoing project and one project that is about to start and this will be the last involvement of WHO in the Quick Start Programme.

2.1.4. In its management response to the evaluation, the WHO Secretariat stated that it currently was or had been an executing agency for 8 out of 118 completed Quick Start Programme projects (and 2 projects under way) and that the recommendations relevant to executing agencies would be fully taken into account where possible in the current projects. Major lessons learnt were: (i) the need to include a more explicit knowledge management and knowledge-sharing component in each project; (ii) ensuring alignment of project objectives in order to ensure ownership and longer-term sustainability of the project results; and (iii) the essential contribution of Quick Start Programme-supported projects to institutional strengthening and more efforts should thus be made to ensure that this was addressed and built into the design and implementation of future projects.

Section No.	Recommendation	Management Response	Key Actions	Time Frame	Responsible Unit(s)	Status	Comments
NB: this evaluation and the recommendations were directed at the SAICM Secretariat at UNEP, which is responsible for the implementation of the QSP. WHO is one of a number of organizations that have been executing agencies for QSP projects. Some of the recommendations are applicable to WHO where they concern project implementation and this is reflected in the remarks given below. The QSP was a time-limited programme and is coming to an end. PHE/IHE has one project that is about to start and this will be the last involvement of PHE in the QSP.							
140	The Quick Start Programme (or a similar chemicals and waste financing mechanism) should be further developed beyond enabling activities, to support national efforts for SAICM implementation by filling specific gaps and kick-starting government own programmes on chemicals and wastes. Externally provided finance should be clearly linked to national frameworks and initiatives, with proposals making clear commitments for government inputs (co-finance) and/or expected actions during and after the project. The proposals should also provide for stronger industry participation in cost sharing (e.g. as cofinance or through longer term approaches such as economic instruments). Closer integration with national contexts may make projects less amenable to closely following international, generic guidance (such as National Profile development or UNEP/UNDP mainstreaming) but will require more active support in adapting these to existing government planning and budgeting processes.	Accepted	Alignment of WHO supported QSP activities with Country Cooperation Strategy (CCS) agreed with Ministry of Health.	ongoing	EPE	In progress	The CCS is a framework for WHO technical support to a given country that is agreed with the Ministry of Health. It ensures alignment of technical work with national health development priorities and objectives. In this way, WHO supported QSP activities are aligned with national efforts.
141	Given the impact of the CSO projects financed through the QSP, stakeholders should ensure that funding for this sector is available in future financing mechanisms. Two of the pillars of the integrated approach (government mainstreaming and industry participation) may be difficult for national CSOs to access, suggesting that the third pillar (external financing for chemicals and wastes) will remain important to ensure that civil society can continue to effectively contribute to chemical and waste governance and implementation at the national level. This may be particularly relevant for LDCs and SIDS countries where chemicals and wastes are not immediate government priorities and it may be difficult to demonstrate that external finance will be effective in integrating chemical management priorities into government work plans and budgets. All recipients of funds (executing agencies, government ministries and CSOs) should be paid in tranches that are aligned to project deliverables.	Other	Not relevant	..	..	..	WHO supported QSP activities are implemented directly with Ministries of Health and related health agencies. CSOs can be involved in projects, for example in stakeholder engagement activities or in workshops subject to the approval of the Ministry of Health of the Government requesting the QSP initiative.
142	Projects should be results-focused, with clear articulation of beneficiaries and intended changes toward the 2020 goal, and more objective, gender-sensitive indicators to measure progress against. Project proposals should clearly articulate specific beneficiaries of projects, along with clear expectations of changes that they will experience – including objectively verifiable indicators to measure these changes. Careful attention should be paid to quantifying and providing evidence for improvements in coordination and exchange between different departments; and for improvements in awareness by policy makers and end users. Gender-related indicators and sex-disaggregated data should also be explicitly required in project proposals and M&E. Evaluators and reviewers need to be independent of project implementers in all cases.	Accepted	WHO's existing policies on gender and equity mainstreaming are adhered to in the context of all projects as applicable.	ongoing	EPE/IHE	In progress	Examples of applications of such policies to WHO's work can be found in the *Roadmap for action, 2014-2019 Integrating equity, gender, human rights and social determinants into the work of WHO (* http://www.who.int/gender-equity-rights/knowledge/roadmap/en/)
143	Management of the portfolio of projects should be more adaptive, with increased capacity for both administration and knowledge management by the secretariat, TFIC and EB. More resources are needed to ensure that the very large number of projects can be efficiently administered, including better use of technology and adequate resources for financial reporting and management, as well as oversight and control of project reporting and M&E (see also Recommendation on results based indicators above). Effort should be also be made to facilitate sharing and proactive dissemination of knowledge from all projects, including using knowledge management technology to establish document repositories (project deliverables) and facilitate exchanges between project implementers (see Recommendation on south-south cooperation below). Options could include development of a QSP-specific resource, or integration of QSP knowledge into existing initiatives and clearing houses for chemicals information.	Other	As an executing agency PHE disseminates the results of projects through its own publications.	ongoing	EPE/IHE	In progress	e.g. http://www.who.int/ipcs/poisons/centre/study_afro/en/ WHO does not maintain a specific knowledge platform for QSP activities and disseminates lessons learned from such activities through its existing information dissemination architecture. WHO would welcome the opportunity to conduct more knowledge management activities in support of these wider QSP objectives. This would be greatly facilitated if knowledge management activities were permissible as an expenditure type in QSP projects.

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144	External financing should more strongly support south-south cooperation including regional experience sharing and joint activities between neighbouring countries. Stakeholders should consider how to best encourage countries to learn from others in their region (and beyond) who have had successes in implementing SAICM, both through access to examples of outputs (national strategies, training materials, legislation, enforcement programmes, etc.) including through improved knowledge management and through development of networks of experts, regulators, and chemical users. In addition to facilitating experience sharing, projects can also include joint activities with explicit outcomes; a particularly relevant case may be on increasing attention to OPS Objective E on illegal international trade through joint training, strategy development and enforcement actions by customs authorities from neighbouring countries with shared borders.	Accepted	PHE has developed a Chemical Risk Assessment Network, with a sub-network for developing countries. The aim of the network is to share information and support capacity development e.g. through training and joint projects. While this is not a QSP activity it supports the achievement of the QSP recommendation	ongoing	EPE	In progress	e.g. http://www.who.int/ipcs/network/meeting_update/en/
145	Projects should clearly articulate strategies to ensure that expertise developed during projects remains available afterwards and contributes to SMC at the national level. The use of national experts should be preferred to international consultants, except where the expertise does not exist nationally. As well as technical capacity, proposals that seek to engage with vulnerable and marginalized groups need to demonstrate that staff have expertise in approaches to engaging with such groups. For either national or international consultants, if consultants are to be contracted to deliver on project outputs, this needs to be made explicit in the proposal and credible plans for mentoring/ capacity building of counterparts in ministries fully articulated.	Accepted	Institutional strengthening is an integral component of all national QSP project activities supported by WHO. Where national capacity is limited, international specialist consultants are partnered with national consultants so as to facilitate such capacity development. To the extent feasible and as relevant, WHO supported QSP projects also involve national health institutions (e.g. institutes for public health) so as to also build capacity at the organizational level.	ongoing	EPE/IHE	In progress	
146	Project follow-up should be enhanced, with a focus on project closure to ensure that the momentum developed in an 'enabling' phase is not lost. In addition to a closer link at project inception to government programmes, projects could include a final step of developing realistic and clearly mandated follow-up plans, with (a very limited number of) commitments. Recognizing the very real constraints faced by government and other stakeholders, these commitments could be as simple as providing a six monthly or annual update; and could be linked to existing obligations such as convention reporting. Commitments should be clearly phrased, be assigned and accepted by particular partners; and include some mechanism for monitoring or reporting on their completion.	Accepted	As an executing agency of projects, efforts are made to ensure some continuation beyond the end of the project. WHO-supported QSP activities are aligned with other ongoing national or regional processes as applicable so as to ensure wider political support and ownership of the results.	ongoing	EPE/IHE	In progress	e.g. following the E Africa poisons centre project a training visit was organised for personnel developing a new poisons centre in Tanzania and a multisectoral workshop was organised in Zambia to develop an action plan for establishing a poisons centre (EPE provided technical input and funded an expert from Kenya)
147	More focus on generating country-specific evidence on health and environmental impacts of chemicals, in order to provide justification for improving SMC, and substitution of less hazardous alternatives to both agricultural and industrial chemicals. The issues of costs and benefits need to be better articulated, including full internalization of the health and environmental costs by both industry and policy makers. Low levels of adoption of alternatives or substitution of hazardous chemicals cannot be addressed as a stand-alone project, or by projects that only target end users, but need to be integrated into high level policy and legislation.	Accepted	As an executing agency of projects this will be incorporated into future projects to the extent possible. As WHO projects involve the health sector this is the sector where we would have influence, rather than in industry or agriculture. Examples of existing (non QSP) activities include evaluation of alternatives to DDT for vector control and phasing out the use of mercury in health care. In addition, PHE is working to increase health sector input into SAICM so that, amongst other things, this sector can use evidence of health impacts of chemicals to influence chemicals policy.	ongoing	EPE/IHE/ WSH	In progress	Draft resolution for WHA 69 is under development: The role of the health sector in the Strategic Approach to International Chemicals Management towards the 2020 goal and beyond

2.2. International Classification of Diseases 11th Revision Review (2015)

2.2.1. The 11th Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-11) project started in 2007. Periodic revisions are necessary to address advances in medicine, science and information technology. In response to some concerns about whether the eleventh revision can remain on schedule, WHO commissioned a review of the revision process in October 2014 by a team of external evaluators to obtain an independent view of progress on both the content and the process of the revision. The final report of the interim assessment of the 11th revision process was delivered on 15 April 2015.

2.2.2. The main technical support to the project has been provided by the network of WHO collaborating centres, with financial contribution by global partners. A beta version of ICD-11 was produced in 2014. The evaluators solicited inputs from a wide range of stakeholders as well as from the Secretariat by means of a structured questionnaire and interviews.

2.2.3. The report noted important advances and concluded that the infrastructure required for this project is now in place. The eleventh revision appears to be achievable with tight project management and clear and realistic goals for completing the task of making the morbidity and mortality statistics comparable and reviewing the current product. However, it also expressed concerns about the delays due to the complexity of the task and the limited resources. Much work still needed to be done to ensure relevance to different types of users and to maintain compatibility with ICD-10 for statistical purposes.

2.2.4. A number of detailed recommendations were made in the areas of goal definition; project oversight; strengthening the Secretariat's internal capacity; project planning and management; communication, marketing, outreach and transparency; governance; creating trust; and education during and after field trials. The project focus should now shift to completing a stable version of the ICD-11 that can be used for mortality and morbidity statistics.

2.2.5. In its management response of May 2015, the Secretariat noted that, thanks to the tireless inputs from 20 scientific topic advisory groups and other working groups, important advances regarding the technical development aspects of the project had already been made during its phase I. These included a major increase in the volume and quality of the contents of the classification as compared to ICD-10, a common foundation component and advanced new electronic editing, translation and information-sharing tools which are freely available to all stakeholders.

2.2.6. It fully agreed with the suggested focus of phase II of the project and supported the recommendations of the report as well as its proposed time scale which underpinned a revised project plan designed to ensure that the eleventh revision would be ready to be considered for adoption by the Seventy-first World Health Assembly in 2018.

2.2.7. As reported to the Executive Board in document EB139/7, the Secretariat has already implemented key recommendations by enhancing technical staffing and management as well as by establishing an expert task force on mortality and morbidity statistics. By the end of 2015, more than 5 000 proposals had been received for changes in the beta version, and more than 90 % of these had been dealt with by the Secretariat by 1 March 2016.

2.2.8. A Release Candidate of the ICD-11 will be presented to Member States and global stakeholders at the ICD Revision Conference in Tokyo, Japan, 12-14 October 2016. This package will include an online version and related information for use in pilot studies and filed testing. The conference will demonstrate features of the eleventh revision, consult on implementation approaches, and pave the way for testing.

For the management response, see
http://www.who.int/classifications/icd/whoresponseicd11.pdf?ua=1

2.3. “Piloting Climate Change Adaptation to Protect Human Health”, a joint UNDP/WHO project funded by the Global Environment Facility (2015)

2.3.1. The Pilot Programme on Climate Change Adaptation to Protect Human Health covered seven geographically diverse countries (Barbados, Bhutan, China, Fiji, Jordan, Kenya, and Uzbekistan). It was the first full-size project funded by the Special Climate Change Fund of the Global Environment Facility (GEF) that piloted and demonstrated how adaptation can reduce health vulnerability to climate variability and change. This global project was designed to increase the adaptive capacity of national health system institutions, including field practitioners, to prepare for, respond to and recover from the health risks of climate variability and change. It was developed in collaboration between UNDP and WHO, with the former being the implementing agency and the latter the executing agency and main provider of technical support to ministries of health in pilot countries.

2.3.2. The statutes of the GEF require both a mid-term and a terminal external evaluation for all projects funded. The objective of this terminal evaluation was to assess project performance against expectations set out in the project logical framework, namely the criteria of relevance, effectiveness, efficiency, sustainability, and impact. The focus of the terminal evaluation was on the project’s success in achieving results, paying more attention to those activities not covered by the mid-term evaluation in May 2013, while taking into account the GEF evaluation objectives at the project level, i.e. (i) to promote accountability for achieving GEF’s objectives; and (ii) to promote organizational learning, feedback, and knowledge-sharing on results and lessons learned among the GEF and its partners.

2.3.3. Overall, the evaluation concluded that the first global project to pilot climate change adaptation to protect human health was highly successful, with excellent examples of best practice in several aspects, including multi-UN agency cooperation and collaboration, capacity-building and mainstreaming health risks of climate change into policy processes. The design was well thought through, providing a range of lessons learnt that will be helpful for other countries as they start implementing similar health adaptation projects and defining the health component of their national adaptation plans to climate change.

2.3.4. The effectiveness of the project was considered to be evident in the results achieved and the capacities created in the health sector to begin addressing the risks of climate variability and change. In the detailed rating of seven performance criteria related to the project outcomes, its sustainability, implementation, and its monitoring and evaluation, the project received four “highly successful” and three “successful” ratings.

2.3.5. The national projects also showed the value of transferring knowledge and tools to the full range of health system actors, the general public, and decision- and policy-makers. According to the evaluator, the project clearly demonstrated that health protection to manage the health risks of climate change could be effectively mainstreamed into national health policies and plans. Continuing the UNDP/WHO collaboration would be beneficial for

future projects. The evaluation also made recommendations regarding the design, orientation, monitoring, oversight and funding of projects of this kind.

2.3.6. The main lesson for WHO concerned the importance of developing a more systematic approach to policy development, capacity-building and country support so as to ensure the sustainability of results and the effective strengthening of the resilience of national health systems to climate variability and change, including longer-term trends and effects. Based on lessons learnt from the implementation of this and other pilot projects on health adaptation to climate change, WHO developed the Operational Framework for building climate resilient health systems. In light of the experience gathered so far, one of the strategic recommendations emerging as regards WHO's role is the need to mobilize increased support for the health sector in Member States, including international climate finance, by becoming an accredited agency for the Green Climate Fund. This has been proposed as a strategic priority for WHO's work on climate change and health, for consideration by the 139th session of the Executive Board.

Recommendation*	Management Response	Key Actions	Time Frame	Responsible Unit(s)
Future projects would benefit from investing sufficient time into project formulation, to ensure that country ownership, an enabling environment, stakeholder engagement, and other conditions that facilitate project success are maximized. Strengthening cooperation between the health sector and meteorological services in the access and use of climate and health data should be part of the process of project formulation.	Recommendation accepted but just partially under the control of WHO. This project was funded by the Global Environment Facility (GEF) and due to lack of funds, four years passed since it was technically approved until the full development of the project proposal. This fact made it difficult for countries to align the needs identified during the project identification phase to those felt when the full project had to be developed. Also, most of the persons involved in the initial identification were no longer working for the Ministries of Health or no longer holding responsibility for this area of work in the six countries selected for implementation (i.e. Barbados, Bhutan, China, Fiji, Jordan, Kenya and Uzbekistan).	The recommendation related to further strengthening cooperation between the health sector and meteorological services in the access and use of climate and health data has been accepted by WHO and, building on lessons learned from this and other projects, WMO and WHO established a joint WHO-WMO climate and health project office in 2014. The collaboration with WMO is mobilizing and building capacity between national meteorological and health services and all projects being implemented or identified now include strengthening institutional capacity and cooperation between the health sector and meteorological services.	This recommendation was already identified and implemented by WHO before the evaluation of this project took place. The joint WHO/WMO office was established in 2014. Furthermore, all projects being implemented at national level with WHO support make sure that the relationship between national met services and WHO are properly strengthened.	PHE/EPE
UNDP and WHO headquarters were extremely effective partners; continuing that partnership would be beneficial for future projects. Engaging UNDP and WHO headquarters and the regional and country offices in national projects would be effective in supporting implementation, capacity building, sharing lessons learned, and project management.	Recommendation accepted. One of the weaknesses in the implementation of the project identified at national level was the lack of involvement from UNDP country offices. WHO country offices were fully involved as in each of the six pilot countries WCOs were responsible for managing the project and providing all technical support required by the Ministry of Health for the effective implementation of the project. Since this was a pilot project, most of the management and technical support to country offices came from HQ. Now that the approach to building climate resilience health systems has been systematized and the field becomes more mature, this role will be mainly played by WHO Regional Offices.	The collaboration with UNDP has successfully continued over time. Two new multi-country projects on building health systems resilience to climate change, with a total budget of USD 19 million, were technically approved by the Global Environment Facility (GEF) by the end of 2015 and full proposals are expected to be finalized by early 2016. The implantation modality will be similar in that WHO will serve as the executing agency, providing direct support to Ministries of Health in the 10 countries to implement the newly approved projects. In order to ensure further involvement of UNDP at national level, the two new projects on building climate resilient health systems include some activities on climate change policy and planning to be managed by UNDP country offices. Similarly, it is expected that the WHO Regional Offices will play a much more prominent role in the management and provision of technical support to country offices.	Ongoing	PHE/EPE and WHO ROs and COs
It would be helpful to develop guidance on monitoring and evaluation systems for health adaptation projects that could be customized to country needs, while having a consistency that would facilitate comparisons across countries.	Recommendation accepted.	Guidance on monitoring health systems resilience to climate change was developed and included in the WHO Operational Framework for building climate resilient health systems (http://apps.who.int/iris/bitstream/10665/189951/1/9789241565073_eng.pdf?ua=1). Moreover, WHO together with the United Nations Framework Convention on Climate Change (UNFCCC) developed a set of country profiles on Climate and Health (http://www.who.int/globalchange/resources/countries/en/) and launched them during the past Conference of the Parties (COP) to the UNFCCC, which took place in December 2015 in Paris. The country profiles provide relevant and reliable country-specific information about the current and future impacts of climate change on human health, the opportunities for health co-benefits from climate mitigation actions, and current policy responses at country level. In addition they form the basis for longer-term research, monitoring and prioritization of health and climate activities. Strengthening the evidence base, and monitoring progress has become a strategic priority for WHO and it aims to further develop its support to Member States in these areas, and to provide country specific evidence through increasing coverage of the WHO/UNFCCC climate and health country profiles.	2015 and ongoing	PHE/EPE

Recommendation*	Management Response	Key Actions	Time Frame	Responsible Unit(s)	Status
The mix of capacity building used in the project was highly successful, including training workshops, annual meetings, participation in scientific conferences, conference calls, electronic information, and selected visits by WHO headquarters and regional staff. It would be helpful for future projects to have sufficient funding for (1) targeted training courses, such as training on analyzing weather and climate data, or on developing and deploying early warning systems; and (2) more frequent meetings of project teams, particularly early in the project.	Recommendation accepted but not under the control of WHO. GEF rules determined that funds made available under the project were not enough to cover the management and provision of technical support from WHO, which had to be covered from funds made available from other projects. Training on different topics such as sensitivity analysis and design of early warning systems was organized but always back to back to other meetings, so as to use resources in an efficient way. More funds should be made available under future projects to ensure further capacity strengthening at all levels.	Building synergies with other projects on climate change and health has become a priority for WHO. This approach ensures the efficient use of resources as well as sharing of experiences among regions and countries. Moreover, WHO has systematized its approach to capacity building and developed a toolkit for project managers that includes information, resources and tools on all relevant topics related to the implementation of projects on building health systems resilience to climate change. Lastly, WHO aims to scale up the public health response to climate change through, among other things, mobilizing increased support to the health sector in Member States, including international climate finance, by becoming an accredited agency for the Green Climate Fund.	2015 and ongoing	PHE/EPE	Implemented and ongoing
Learning curves on health adaptation are fairly steep at the beginning of a project; holding meetings about every six months for the first two years could support more rapid capacity building on project implementation. Capacity development across the full range of actors from health systems to decision-makers to the general public would be beneficial.	Recommendation accepted. As above, it depends on funds made available for this area of work.	Same as above.	2015 and ongoing	PHE/EPE	Implemented and ongoing
Future projects should explicitly incorporate consideration of longer-term climate change, building iterative management approaches into policies and plans to ensure resilience as the climate continues to change. It also would be helpful for future project to include a specific output to develop a plan for scaling up.	Recommendation accepted.	As included in the WHO Operational Framework for building climate resilient health systems, and the WHO guidance on health vulnerability and adaptation assessment, an iterative management approach is proposed to ensure effective strengthening of resilience to climate change. This approach has been incorporated to all, past and new projects but depending on priorities from countries was more or less developed in practice.	2010 - ongoing	PHE/EPE	Implemented and ongoing
Adaptation is a long-term process. To the extent possible, it would be beneficial to support longer-term projects, to ensure sufficient time for implementation and monitoring and evaluation of results.	Recommendation accepted but not under the control of WHO. This project was approved for a 4 year-period, as per the rules defined by the GEF. Projects depend on the requirements determined by donors.	As stated above, WHO aims to scale up the public health response to climate change. This includes the identification of potential entry points to increase support to health sector in Member States.	2015 and ongoing	PHE/EPE	Implemented and ongoing
*** Please note that the recommendations are not numbered in the evaluation report. The recommendations are in page 59-60**					

2.4. WHO global strategy for the surveillance and monitoring of HIV drug resistance (2014)

2.4.1. The scale-up of antiretroviral therapy in low- and middle-income countries, initiated in 2003, raised concerns on the emergence of HIV drug resistance (HIVDR), given that low adherence, poor patient monitoring and limited drug stocks are commonly observed in resource-limited settings, all of which are known to favour the emergence of drug resistance. An initial strategy for surveillance of HIVDR was therefore designed in 2004 and has been continually revised in recent years with a focus on quantifying the magnitude of resistance and transmission and providing robust elements to inform global treatment guidelines and national treatment programme management.

2.4.2. The objective of the WHO global strategy for the surveillance and monitoring of HIV drug resistance was to monitor the emergence and transmission of HIV drug resistance in resource-limited settings where antiretroviral therapy was being scaled up. An end-of-grant evaluation at the request of the main donor was commissioned in 2014 and was carried out by an independent evaluation team. The evaluation was overseen by a steering committee with membership from WHO, the Centers for Disease Control and Prevention and the Bill and Melinda Gates Foundation. The final evaluation report was submitted in 2014.

2.4.3. The evaluation concluded that the scientific community accorded WHO and its advisory network WHO HIV ResNet legitimacy and credibility for standard-setting. The advocacy for the continued implementation of the HIVDR project is acknowledged to be a challenge, given the low levels of resistance found so far and the decreasing importance of the topic in high-income countries. Furthermore, the strategy was still perceived as more relevant for scientific aspects than for programmatic ones, implying that its advocacy and funding continued to be a challenge. Different partners in countries encourage countries to implement different elements of the strategy, hindering their ability to pursue a consistent strategy. WHO should therefore work on creating a shared high-level action plan with partners to improve their alignment on what should be the priorities for countries.

2.4.4. This plan should include: (i) the further development of the WHO HIVDR strategic plan in line with main partners and donors (clear prioritized recommendations for countries, aligning partners, setting targets for the scale-up plan, robust monitoring and evaluation); (ii) the development and reinforcement of communications and advocacy, including a stakeholder alignment and engagement plan; (iii) the reinforcement of relations with key stakeholders by further formalizing the governance process; (iv) the securing of sustainable funding through strengthened donor relations, more direct funding to countries and integration of HIVDR in HIV; and continued support for the implementation of the strategy in priority countries.

2.4.5. In its management response, WHO stressed its satisfaction with an external, objective assessment based on the strong engagement of its partners. It accepted all the recommendations of the evaluation, the implementation of which was either in progress or already completed: WHO is currently developing a global action plan for HIVDR, which aims at improving partners' alignment and coordination. As to the specific elements of this high-level action plan listed in para. 2.4.4. (i) and (ii) above, recommendations for countries to

prioritize elements of the HIVDR Strategy have been developed and were shared with partners. The relevant document is already available on the WHO website. The plan also includes a monitoring and evaluation framework and targets, as well as a communications and advocacy strategy.

2.4.6. Regarding the governance process (element (iii) in para. 2.4.4. above), an HIVDR steering group is already in place and includes main stakeholders. Based on the recommendations, the governance of the steering group was further formalized and membership of the WHO HIV ResNet steering group expanded to include programmatic partners as well as clinicians. With respect to element (iv) (i.e. funding and implementation support in priority countries), the funding issue is being addressed through re-defining a HIVDR resource mobilization strategy in the global action plan. WHO continues to support priority countries in survey implementation and the build-up of laboratory capacity for HIVDR through the expansion of the global HIVDR laboratory network. Through consultation with the Global Fund, it furthermore advocates for the inclusion of HIVDR surveillance in Global Fund concept notes for funding.

2.4.7. Overall, the recommendations of the evaluation were thus seen as meaningful and would empower WHO to formulate a more strategic approach through the development of a global action plan for HIV drug resistance which is currently ongoing. It was expected that this would lead to better partner alignment with increased buy-in, as well as more focused work on priority interventions with greater impact in countries. The evaluation in itself has, however, so far not led to stable or increased funding, as key donors have not yet followed up on all its recommendations. Nevertheless, useful lessons learnt from this evaluation for broader applicability in WHO include the importance of alignment of all stakeholders through an agreed strategic plan; the need to focus even more on communications and advocacy; and the need to constantly improve donor relations and fund-raising.

Section No.	Recommendation	Management Response	Key Actions	Time Frame	Responsible Unit(s)	Status	Comments
1	Further develop WHO HIVDR strategic plan in line with main partners and donors • Define clear recommendations. for countries, aligning partners and allowing countries to prioritize elements of the strategy • Set targets for the scale up plan (timing, target countries for each element), in line with key donors / partners • Build robust M&E plan in line with donors' expectations	Accepted	Recommendations for countries to prioritize elements of the HIVDR Strategy were developed and shared (document available on the WHO website)	2015	HIV/TAC	Completed	
	same as above	Accepted	WHO is currently developing a Global Action Plan for HIVDR, which aims to improve parners alignement and coordination and includes M&E framework and targets.	2017	HIV/TAC	In progress	
2	Reinforce advocacy for HIVDR and links with programmatic aspects • Define communication /advocacy strategy and identify relays in a communication plan (part of the strategic plan described above) • Develop a stakeholder alignment and engagement plan (part of the strategic plan described above) to serve as advocacy tool • Include Advocacy as a standing agenda point for the Steering Group, and invite advocacy experts	Accepted	The Global Action Plan that WHO is developing includes a communication and advocacy startegy	2017	HIV/TAC	In progress	
3	Reinforce relations with key stakeholders • Further formalize governance (advisory bodies ToRs meeting frequency and agenda, feedback process) • Reinforce the role of the Core group to get input on data quality issues, survey methodology revision	Accepted	An HIVDR Steering Group for HIVDR is already in place, and includes main stakeholders. Based on the recommendations, governance of the Steering Group was further formalized and membership to the HIVResNet Steering Group expanded to include programmatic partners as well and clinicians. Inputs from technical WG are requested as needed to develop guidance documents.	2014	HIV/TAC	Completed	Governance was already in place. This recommendation may reflect a desire to have broader partner inputs to the steering group.
4	Secure sustainable funding Advocate for awareness of HIVDR strategy and integration of HIVDR in HIV • Reinforce donor relations (organize regular donor meetings and ensure donor reporting) • Work with major donors on direct funding to countries and modalities to support the scale up plan through WHO	Accepted	The HIVDR programme has moved in 2015 into the HIV Treatment and Care unit (TAC) , creating greater opportunities to integrate the programme with the treatment and care programmes at country level. The Global Action Plan that WHO is developing includes a resource mobilization strategy. Meetings with GF and BMGF, and regular calls and meeting with PEPFAR were done.	2017	HIV/TAC	In progress	Regular donor reporting was already done at the time of the evaluation. WHO has limited capacity to influence mechanisms for funding country activities directly from main donors (PEPFAR, GF); however WHO has worked closely with the Global Fund To ensure that countries can reprogramme funds to cover the PDR and ADR surveys.
5	Continue to support implementation of the strategy in priority countries and link with programmatic aspects • Support countries in finding funding (see above) • Ensure country feedback on survey implementation is well integrated, including the development of a formal process and feedback form • Develop guidance for prioritization of the strategy and for response with clear, high-level guidance outlining how to prevent HIVDR based on results of the surveillance • Continue to support laboratory expansion, focusing on HIVDR priorities and continue to be active in encouraging expansion of capacity to perform genotyping in DBS • Coordinate and / or provide TA to build capacity for surveys and for laboratories	Accepted	HIV/TAC continues to support countries in survey implementation and provide remote and direct TA, including laboratory capacity for HIVDR. HIV/TAC dialogues with GF and advocates for the inclusion of HIVDR surveillance in GF concept notes for funding. HIV/TAC continues to expand the global HIVDR lab network and support use of DBS for genotyping; in addition it plans to develop guidance of public health actions in response to survey findings	NA	HIV/TAC	In progress	

2.5. Immunization Practices Advisory Committee (2015)

2.5.1. WHO established the Immunization Practices Advisory Committee (IPAC) in 2010 under the auspices of its Expanded Programme on Immunization in order to provide independent evidence- and experience-based advice and recommendations to strengthen and improve the delivery of immunization programmes at the country level. In 2014, the Immunization Practices Advisory Committee shifted to a new operating modality and it was considered timely and relevant that the Committee's mandate, structure, evolution and processes be re-examined and evaluated to ensure its continued relevance and utility. This evaluation was carried out by an independent external evaluation team and the final report was submitted in November 2015.

2.5.2. The evaluation concluded that the Committee's advice to WHO and its contribution to immunization operational practices are widely viewed as successes. However, it still lacks a recognized « voice » in the immunization community and more strategic thought needs to be given to its future role and directions. The evaluation's recommendations are focused on optimizing and strengthening the new operating modality, which is considered innovative and could serve as a model also for other WHO advisory committees. The Committee's operational structure should transition to one that: (i) is more formalized and has a higher profile within WHO, the Strategic Advisory Group of Experts on immunization, and other WHO-sponsored groups and immunization partners; (ii) is more responsive to WHO's current needs; (iii) is more virtual and thus less resource-intensive; and (iv) contains strengthened regional and country-specific expertise and support on immunization practices.

2.5.3. Other recommendations included (i) strengthening IPAC documentation and communication on its purpose, role, organizational relationships and achievements; (ii) developing a two-year strategic plan; (iii) enhanced support of IPAC members tasked to external workgroups; (iv) better recruitment and briefing of new IPAC members, including a mentor system and a more formal orientation package; and (v) development of performance benchmarks for periodic IPAC evaluation.

2.5.4. All recommendations were accepted or partially accepted by the Secretariat and are being implemented. A meeting in February 2016 of relevant senior technical staff in WHO discussed IPAC's functions, relationship with other committees, and forward agenda. An agenda prioritization exercise as well as appropriate IPAC website revisions are under way. A strategic framework is being developed, which also includes a communications plan. Meetings with secretariats and chairs of various external working groups or committees, as per para. 2.5.3., have been held to discuss their relationship with IPAC, including IPAC representation on them.

2.5.5. The member profile on the IPAC Call for Nominations has been revised to reflect more precise requirements as to skill sets and regional representation. New IPAC members have been "paired" with "veteran members" to serve as mentors. The IPAC discussion forum has also been rendered easier to use through improvements of features of the TechNet platform and discussion forum. Finally, improved performance benchmarks are being identified as a key step in the preparation of IPAC's strategic framework.

2.5.6. As the report was only recently released, concrete improvements stemming from the ongoing implementation work, as listed in paras. 2.5.4. and 2.5.5. above, are only expected to materialize gradually, and mostly as of May 2016. Important lessons already learnt, however, are that change management requires increased communication to all parties involved and that senior-level interest and engagement within the Secretariat is critical to ensuring the accomplishment of the Committee's mission and outputs. The various recommendations on how to strengthen the IPAC Committee structure, membership, and mode of operations could well become a model for "best practice" in setting up or reforming other WHO committees of similar advisory groups.

Section No.	Recommendation	Management Response	Key Actions	Time Frame	Responsible Unit(s)	Status	Comments
1	Maximize IPAC's value and outcomes: WHO should take steps to strengthen documentation and communication on outcomes of IPAC work/recommendations, especially successes, and establish future planning for documentation and communication. This should be done internally with WHO leadership, amongst IPAC Members, external partners and the broader immunization community. WHO may consider developing a "History of IPAC" report.	Partially accepted	1) Meeting in February 2016 of IVB senior technical staff to discuss IPAC's function, relationship with other Committees (e.g. PD-VAC) and forward agenda 2) Agenda prioritization exercise under way 3) Revisions of IPAC website under way 4) Communications plan to be developed and incorporated into Strategic Plan under development	Feb - Apr 2016	IPAC Secretariat (EPI)	In progress	It was agreed that the "History of IPAC" report would not bring added valued and that a forward looking response would be more constructive.
2	Strategic plan: With the collaboration of the IPAC Chair and Members, WHO should lead development of a 2-year IPAC strategic plan that details, for example, the Committee's objectives, meeting plan, provisional agendas and workplan. The plan should provide for mechanisms to allow flexibility and responsiveness to changing WHO needs.	Accepted	1) Document development plan already agreed 2) Outline of content under discussion	Feb - May 2016	IPAC Secretariat (EPI)	In progress	An initial document outline was shared with the Chair of the Committee for comments and is now being revised to be shared with Committee members. Their input will then be incorporated into a version to be approved by the IVB Director.
3	Clarify and better communicate IPAC's purpose, role, organizational relationships and achievements: WHO should clarify, document, and make senior-level statements on IPAC's purpose, organizational relationships, lines of communication, with for example, SAGE, VPPAG, PSPQ, and IVIR-AC.	Accepted	1) Meeting in February 2016 of IVB senior technical staff to discuss IPAC's function, relationship with other Committees (e.g. PD-VAC) and forward agenda 2) The strategic plan will address the organizational relationships and lines of communication 3) Senior IVB staff will be invited to join the IPAC Discussion forum on TechNet	Feb - May 2016	IPAC Secretariat (EPI)	In progress	This recommendation is very linked to the first and so the responses are combined.
4	Improve and support tasking of IPAC Members to external workgroups: WHO should take steps to improve support to IPAC Members tasked to SAGE workgroups, VPPAG, PSPQ, IVIR-AC, or others	Accepted	Meetings with Secretariats and Chairs of these various Committees have been held to discuss relationship with IPAC, including representation.	Nov 2015 -Feb 2016	IPAC Secretariat (EPI)	Implemented	
5	Better orient and recruit new IPAC Members: A support system should be developed for new IPAC Members. For example: develop a more formal orientation package and process; formally or informally assign mentors to new Members; and for those new Members whom WHO may find it appropriate, engage immunization staff from the new Member's associated WHO Regional Office or WHO Country Office to provide orientation and other support during the member's tenure or provide liaison between WHO and the IPAC member. IPAC should broaden and regionalize its Membership to include more country-level field and implementation expertise.	Partially accepted	1) The member profile on the IPAC Call for Nominations has been revised to reflect more precise requirements, including regional representation, both in terms of skill sets and geographic representation 2) New members have been paired with "veteran members" to serve as mentors	Oct 2015 - May 2016	IPAC Secretariat (EPI)	In progress	Four new members will be selected following an April 2016 Call for Nominations, after which extra efforts will be made to ensure a smooth and well-supported integration into the Committee. It was not considered useful to engage the regional or country offices in member orientation, as this could prove an unnecesary burden on those offices, but should a pronounced need arise, this option will be considered.
6	Bolster IPAC internal communication: There should be strengthened training and promotion of the TechNet Forum for IPAC communications and perhaps more intensive training for less technologically proficient Members.	Accepted	1) The TechNet platform and discussion forum features have improved, rendering the IPAC discussion forum easier to use and navigate. 2) Two webinars sesssions have been scheduled (following a Doodle poll to ensure maximum member availability) to provide training and orientation to IPAC Members on the new features and how best to utilize this essential communication tool for the Committee.	Feb-March 2016	IPAC Secretariat (EPI)	In progress	
7	Identify performance benchmarks and evaluate IPAC in two years: IPAC outcomes and performance should be assessed. Benchmarks should be identified and based on both WHO's needs for expert advice on immunization practices and established measures for the performance of IPAC.	Accepted	The identification of benchmarks is a key step in the preparation of IPAC's Strategic Plan.	Mar-16	IPAC Secretariat (EPI)	In progress	

2.6. Independent Monitoring Board of the Global Polio Eradication Initiative (2015)

2.6.1. The Independent Monitoring Board (IMB) of the Global Polio Eradication Initiative (GPEI) was established in 2010 to monitor and guide the Initiative's work. It meets every six months with representatives of Member States in which poliomyelitis is endemic, WHO and its Eradication Initiative partners and, after each meeting, reports on its independent assessment of the progress being made in the detection and interruption of poliovirus transmission globally. Its twelfth report, issued after the Board's meeting in London (5 to 7 October 2015) concluded that the number of cases up to that point in 2015 was at its lowest point in history. Nigeria having recently been removed from the list of countries endemic for polio, only two remained: Afghanistan and Pakistan. This should be considered a major achievement.

2.6.2. The IMB's six-monthly evaluations represent a process of continuous learning for the GPEI as well as for WHO's disease eradication efforts more generally, since polio eradication represents the area with the most accumulated experience of relevance for these efforts. The major specific lesson from this evaluation was the need to accelerate programme improvement in Afghanistan and Pakistan. There have been several more general lessons from these evaluations, which have all been incorporated into the management approach of the GPEI programme. These have been the need to innovate, to operate in close-knit partnerships at national level and to strengthen the governance arrangements of the GPEI. The latter has been achieved through the establishment of a Polio Oversight Board, which is responsible for oversight of the Eradication Initiative and includes the WHO Director-General as one of its members, and by the establishment of a clear cross-GPEI system of management groups, each with clear terms of reference.

2.6.3. The Polio Oversight Board concluded in a formal voting decision in September 2015 that the most likely outcome of its scenario analysis was that polio transmission would be interrupted in 2016 and eradication would be officially certified by 2019. The report concluded that this bold target was possible, but required an improvement from current performance. The adopted target scenario, which set a new timescale and formal deadline for the programme, would require additional funding of US$ 1 500 million on top of the budget already earmarked for eradication. Should transmission not be interrupted by 2016, a further at least US$ 800 million per year would be needed to deal with the consequences. This figure could easily reach US$ 1 000 million per year. Referring to this new timescale, the IMB in its report recommended five key measures as the minimum required to create a realistic chance for achieving the new deadline.

2.6.4. In its management response, the Secretariat stated that it valued the process of continuous learning represented by the six-monthly IMB reports. WHO's Director of Polio Eradication chaired the Strategy Committee of the GPEI, which oversees the response to these recommendations. In collaboration with its GPEI partners, WHO had completed or set in motion actions to execute all the IMB's recommendations. The most substantial evolution had occurred within its programme in Afghanistan, where WHO now worked with partners in an Emergency Operations Centre at national level and in two centres at provincial level.

Section No.	Recommendation	Management Response	Key Actions	Time Frame	Responsible Unit(s)	Status	Comments
	PAKISTAN AND AFGHANISTAN						
1	All partners in the GPEI, and the Afghanistan government, should work with the greatest possible urgency to establish an Emergency Operations Centre in Afghanistan that has a level of functionality equivalent to the comparable Centre that has been transformational in Nigeria.	Accepted	National and 3 regional EOCs (Kandahar, Jalalabad, Herat) now established. MOH and Partners are supporting full implementation of the NEAP and enhancing data management support for national and provincial EOCs. Full functionality of EOCs still evolving, including assuring availability of dashboards showing real-time data for improving SIAs in LPDs. Data management in Regional EOCs lags behind national EOCs; national EOCs now beginning to visit and monitor Regional EOCs. Accountability monitoring is in the process of being implemented. There has been incremental improvement in quality of SIADs, but 7-10% children still being missed in 5 key provinces.	Dec-15	POL/SSC	Completed	
2	Non-Governmental Organisations that contribute to polio eradication in Afghanistan should be full members of the new Emergency Operations Centre.	Partially accepted	Proposal being considered to have Grants and Commissions Management Unit (MoH GCMU, manages the PBHS partners) represented in the EOC also. Partners are engaging IFRC to assist with negotiating and working in inaccessible districts and other high risk LPDs.		POL/SSC	In progress	
3	The GPEI partners and the government of Afghanistan should rapidly review and redesign leadership, accountability and coordination arrangements for the polio programme in the country to establish a new sense of direction.	Accepted		Dec-15	POL/SSC	Completed	
4	The GPEI partners should help the governments of Pakistan and Afghanistan to establish a joint executive and planning body to instigate cross-border polio prevention and control; this should not only address the border crossings but take account of the need to cover communities at some distance from the border itself. One option would be to set up a joint governmental Emergency Operations Centre but leaders of the programme must ensure that the organizational model is much superior to the ineffectual arrangements of the past.	Accepted	Improved Coordination: WHO EMRO, in consultation with GPEI, assigned two Medical Officers as advisors to Pakistan and Afghanistan respectively to assist Pakistan and Afghanistan on common WPV reservoirs coordination. Coordination has significantly improved between the FATA and eastern Afghanistan teams with monthly in person meetings and video conferences since November 2015. A video conference was convened between the national teams on 6th January. National in-person meeting planned for 9th March in Kabul. Improving cross border operations: • Mapping of bordering villages at Khyber – Nangarhar border completed. • The transit vaccination strategy revamped by Pakistan on Torkham border between Khyber & Nangarhar. • Reassessment of the vaccination posts and supervisory mechanisms followed by substantial rise in the number of teams & supervisors (almost four fold). As a result, the monthly coverage at Torkham border increased from an average of 40,000 to almost 100,000 in December 2015 & January 2016. In addition, the age group for transit vaccination at the border crossings increased up to 10 years.	Dec-15	POL/SSC	Completed	

Section No.	Recommendation	Management Response	Key Actions	Time Frame	Responsible Unit(s)	Status	Comments
	PAKISTAN AND AFGHANISTAN						
5	The GPEI and the government of Pakistan should give top priority to stopping polio transmission in Peshawar and surrounding regions. This should include urgently addressing the mismatch between the "epidemiological" geography of polio and the "planning and coordination" geography in this part of the country. Serious consideration should be given to reconfiguring the regional Emergency Operations Centre arrangements to address this. Support to these regions should include expert technical assistance in managing and using data at the local level; the GPEI senior leadership should help to design the essential data flow.	Accepted	With support of GPEI, a committee chaired by Commissioner Peshawar has been established with the objective to treat the whole area as one region for operational and security purposes. This committee meets before each round (4 times to date) and includes representative of HQs 11 Corps; Deputy Commissioner Peshawar (for Peshawar districts and FR Peshawar); Political Agent (for Khyber Agency); DIG Peshawar; Assistant Political Agent (for FR Kohat); District Health Officer Peshawar; Agency Surgeon Khyber; Agency Surgeons FR Peshawar and FR Kohat; representatives of Mohmand Agency, districts of Charsadda and Nowshera and partners' staff in Peshawar district, Khyber Agency, FR Peshawar and FR Koha. To date all the UCs of Peshawar and the villages on FATA side on the borders have been clearly mapped. Micro-plans of the bordering UCs / areas have been field validated and all the ambiguities have been removed. Joint trainings for the Area In-Charges and polio teams were organized. The activities on both sides have been synchronized (starting on the same day). Data use in KP/FATA is quite comprehensive, with the NEOCs supporting analysis of data on a daily basis of LQAS, PCM, ICM, and Market Surveys. ICM, PCM and LQAS is now possible in every UC of Town 4 in Peshawar, and the LQAS pass percentage in the Peshawar corridor has risen to 84% pass (86% in Town 4). The Prime Minister's Focus Group discussed the importance of this region during its meeting in December 2015. The Prime Minister Office has assured the KP and FATA teams of any additional support from the Federal Government and law enforcement agencies to effectively tackle the risk in Khyber – Peshawar Conveyer Belt. WHO has appointed one Short Term Consultant (STC) for this region; and two High Risk Coordinators, one each in KP EOC and FATA EOC. WHO has appointed two senior staff members as Common Reservoir Coordinators. A one-day Afghanistan-Pakistan Coordination meeting on common WPV reservoirs will be held on 9 March in Kabul.	Dec-15	POL/SSC	Completed	
6	The CDC should conduct an urgent special review of the pattern and genetic features of the positive environmental samples in different geographical areas of Pakistan. The primary aim of the review should be to identify possible pockets of population that may have been missed in previous microplanning. It is essential that this work is completed in time to be able to inform the current low season vaccination rounds.	N/A - recom to CDC					
7	The most senior members of the GPEI should work with the leaders of the polio programmes in Pakistan and Afghanistan to plan a precisely targeted series of campaigns of IPV alongside OPV. The IMB has repeatedly stressed the immunity benefits of this but it is essential, given limited vaccine supply, that it is used to prioritise, through microplanning and microcensuses, hard-to-reach and persistently missed children.	Accepted	The Strategy Committee of GPEI, chaired by WHO, endorsed updated guidelines for use of IPV in campaigns in Pakistan and Afghanistan in the context of a very limited global IPV supply, agreed on additional IPV allocations for use in SIAs in Afghanistan (496,960 doses) and Pakistan (740,220 doses), and allocated 400,000 doses as global emergency stock, to be shipped out based on emerging needs and in strict adherence with the global guidelines on IPV use in SIAs. This decision was communicated to countries on 6 December 2015. There was an emphasis on the need for country teams to ensure IPV SIAs are implemented to achieve at least 80% coverage or pass rate from independent monitoring/LQAS or a clear trend of consistent coverage improvements. Operational plans are being finalized for the IPV+OPV SIAs in high-risk areas during March to May 2016 and both country teams are expected to review their current stocks and utilization and submit any request for additional IPV supply needs by mid-March for the Strategy Committee to consider.	Nov 15 - Jan 16	POL/ODI	Completed	

Section No.	Recommendation	Management Response	Key Actions	Time Frame	Responsible Unit(s)	Status	Comments
	NIGERIA						
8	The GPEI leadership should work with the Emergency Operations Centre in Nigeria to strategically review the range and adequacy of data streams to monitor the country's resilience to polio transmission becoming reintroduced. From this, a Polio Resilience Dashboard should be constructed that would become the main vehicle for directing vaccination strategy.	Partially accepted	A polio dashboard is 'live' and tracks a set of indicators used to assess program and management performance; the national emergency plan includes a set of activities designed to close loopholes in surveillance and implementation that would increase 'resilience'.		POL/SSC	In progress	
9	A new Director of Polio Legacy should be appointed to lead legacy planning in Nigeria and to ensure that programme staff and leaders are not distracted from the task of building resilience to keep the country and the rest of Africa free of polio until official certification.	**N/A - recom to government**					
10	The GPEI should conduct a new social mobilization and communication campaign to raise awareness amongst parents and health professionals that polio vaccination is still necessary to protect children from the disease.	N/A - recom to UNICEF					
	UKRAINE						
11	The government of Ukraine should ask the GPEI to assist it by establishing an independent international panel to advise on dealing with its polio situation and also to assist with investigating cases of alleged adverse reactions to polio vaccine, an issue that has damaged past public confidence in vaccination. The panel would also be a credible source of public information untainted by vested interests.	N/A - recom to government					
12	The International Health Regulations Review Committee should be asked to declare the situation in Ukraine a public health emergency. It is strongly recommended that the rules be changed to allow vaccine-derived polio viruses, to fall within the scope of the regulations.	Accepted	On 10th November 2015 and 12th February 2016, the IHR review committee included Ukraine on the list of polio infected countries in its new recommendations. The Ukraine team participated in deliberations of the committee in November. The IHR RC included cVDP Viruses in scope for committee review going forward. The recent February assessment of the EC is that the current epidemiology continues to constitute a Public Health Emergency of International Concern (PHEIC), both for countries affected by wild poliovirus and countries affected by circulating vaccine-derived polioviruses (cVDPVs).	Nov-15	POL/SMI	Completed	
	REFUGEE AND MIGRANT COMMUNITIES						
13	The GPEI, working through the WHO EMRO and EURO offices, should conduct a more detailed risk assessment around polio immunity in migrant and refugee communities from conflict in the Middle East – including those not housed within formal structures. Further supplementary immunization activities should be considered in Jordan, Lebanon, and Turkey and on migratory routes into Europe, depending on their findings.	Accepted	High level meeting of ministers of health of European States held on 23rd to 24th November 2015 to discuss issues related to refugee / migrant health, including Polio. EMRO representatives and countries affected by the migration attended the meeting.		POL/SSC	In progress	
14	Middle Eastern countries with refugees from Syria should advertise free vaccination for children without the need for official registration or identity checks.	N/A - recom to government					

Section No.	Recommendation	Management Response	Key Actions	Time Frame	Responsible Unit(s)	Status	Comments
	PROGRAMME-WIDE POLICY AND ACTION						
15	The GPEI should introduce, as a matter of policy, a "Golden Rule" that in all security compromised areas a single integrated plan (incorporating both programatic and security elements) should be produced before every vaccine round or other polio-related activity in an area. This would have the purpose of tightly coordinating security arrangements with planned polio technical activity. It would be agreed by all parties and communicated to all teams.	Partially accepted	The proposed "Golden Rule" of integrating security and programmatic elements into one single plan cannot be implemented uniformly in all countries, and has to be modified according to the local political and security context. In Pakistan, LEAs and the Military are fully engaged in the EOCs, and the micro-plans now include the numbers of optimal security personnel needed in high-risk areas. However, there are still gaps in the numbers of security personnel requested by the programme, and the actual numbers available during the campaigns. Advocacy with local administrative officials, senior officials of the local LEA, and provincial political leaders have been conducted to ensure the optimal numbers of security personnel are made available for each polio activity. The review and updating of the micro-plans after every SIA will further ensure better security coverage. In countries such as Afghanistan, the programme has to maintain strict "neutrality" in its actions and hence cannot engage closely with LEAs and the Military. However, the SRAs help in establishing the dates and scope of the campaigns, in developing alternate vaccination modalities, and provide information that can be utilised in local and high-level negotiations with all parties. Third-party interlocutors, and other channels within the UN are also used to gain advance information of potential security incidents, and help the polio campaign take appropriate risk mitigation measures.	Mar-16	POL/SSC	Completed	
16	The GPEI should deploy its most skilled leadership to organize the response to outbreaks of vaccine derived polio virus in countries other than the Ukraine (where a special initiative is recommended). Currently, these countries are: Madagascar, Lao PDR, Guinea, and South Sudan.	Accepted	Ongoing. The Outbreak Preparedness and Response Task Team (OPRTT) reports regularly to the EOMG and SC, highlighting risks, bottlenecks and improvements to the outbreak response mechanism. All the countries mentioned in the recommendation have an experienced outbreak coordinator. All the outbreak coordinators and communication officers are well trained and experienced health professionals. Some of the challenges encountered with implementing effective outbreak response based on recent experience included inconsistent government ownership and accountability, delays in deployment of capacity and sub-optimal SIA quality. The GPEI will be holding an outbreak response meeting from 23-24 March, giving partners the opportunity to discuss openly the challenges over the past year in outbreak preparedness and response. The meeting will also be a chance to address the post switch outbreak response protocols. Any polio outbreak/event will represent a major threat for the initiative and will need to be responded to in an effective and timely fashion. The VDPV outbreaks and events will follow a new protocol including use of IPV in response. It is critical that all preparations for the pre-switch phase are well-aligned and agencies and partners are well briefed and prepared to carry out post-switch outbreak response.	Mar-16	POIL/SSC	Completed	Initial action completed, but this item is ongoing as further outbreaks arise.

2.7. African Programme for Onchocerciasis Control (2015)

2.7.1. The African Programme for Onchocerciasis Control (APOC) was established in 1995 with the World Bank as the fiscal agent and WHO as the executive agency, and was officially closed on 31 December 2015. Its purpose was to expand Onchocerciasis control to countries[1] that fell outside the scope of the Onchocerciasis Control Programme for West Africa (OCP)[2]. Its approach focused on mass administration of ivermectin, using community distributors. The programme significantly contributed towards the elimination of onchocerciasis as a public health problem.

2.7.2. In accordance with the Memorandum for the African Programme for Onchocerciasis Control and decisions taken by countries endemic for onchocerciasis, nongovernmental development organizations and various donors contributing to APOC at the Joint Action Forum during its twentieth session (Addis Ababa, 8 and 9 December 2014), a final evaluation of the Programme was carried out with the following objectives: (i) to assess the effectiveness and efficiency of the Programme; (ii) to analyse the Programme's wider impact and application of lessons learnt; (iii) to identify best practice and lessons learnt; and (iv) to make available to all its stakeholders appropriate and relevant data, conclusions and recommendations in order to provide a basis for the next project and/or programme focusing on neglected tropical diseases as there had been a fundamental change in approach from control to elimination of onchocerciasis.

2.7.3. The final report was endorsed by the Committee of Sponsoring Agencies of APOC in October 2015 and approved by the Joint Action Forum in December 2015. Its detailed recommendations are addressed in part to WHO, other neglected tropical disease stakeholders and donors and in part to the Expanded Special Project for the Elimination of Neglected Tropical Diseases in Africa (ESPEN). In its response, the Secretariat took several actions before and after the closure of the Programme, in line with the decisions of the Joint Action Forum at its twentieth session to close the Programme by December 2015 and create a "new neglected tropical diseases entity" that will oversee and support accelerated action against all neglected tropical diseases that respond to preventive chemotherapy[3].

2.7.4. These include, but are not limited to, establishment of a working group followed by a wider consultative meeting of neglected tropical diseases stakeholders, which resulted in the establishment of ESPEN; mobilization of human and financial resources for effective implementation of ESPEN; briefing of health ministers on ESPEN during the Sixty-fifth session of the Regional Committee for Africa (N'Djamena, 23-27 November 2015); preparation for the launch of ESPEN on the margins of the Sixty-ninth World Health Assembly; and engagement of neglected tropical diseases partners and countries to scale up interventions against neglected tropical diseases. The ESPEN framework and plan of action respond to all the recommendations made to the Secretariat in the evaluation report.

[1] Angola, Burundi, Cameroon, Central African Republic, Chad, Congo, Democratic Republic of the Congo, Equatorial Guinea, Ethiopia, Gabon, Kenya, Liberia, Malawi, Mozambique, Nigeria, Rwanda, South Sudan, Sudan, Uganda and United Republic of Tanzania.

[2] The Onchocerciais Control Programme for West Africa, which was set up in 1974 in 11 West African countries, focused on vector control.

[3] Lymphatic filariasis, schistosomiasis, soil transmitted helminthiasis, trachoma and onchocerciasis

Detailed information on progress made by the Secretariat on ESPEN will be provided to the governing bodies.

2.7.5. Specifically, and in line with the detailed recommendations of the final evaluation report, a WHO fiduciary fund dedicated to ESPEN was established as trust funds are expected to continue to be an important funding mechanism for onchocerciasis and integrated neglected tropical diseases programming. Donors will be encouraged to support the integrated neglected tropical diseases package wherever possible. National programme managers, who may have concerns regarding the future of onchocerciasis control, will be sensitized on the upcoming ESPEN project and framework and what can be expected from it.

2.7.6. The ESPEN Plan of Action will also pay due attention to developing novel approaches for mass drug administration and neglected tropical disease interventions in urban areas, since urban transmission is a growing problem in areas where there is an important influx of migrants. Through a desk review process, ESPEN induction workshops and country missions, ESPEN will begin with a detailed country-by-country situational analysis of onchocerciasis, taking into consideration recent population movements and ecological or climate changes. This, together with a modern results-based management approach and a careful inventory of country and regional-level technical resources available, will form the basis for defining realistic plans to address treatment priorities, assistance priorities and research needs.

2.7.7. The APOC practice of strengthening health services including human resources, rather than just mass drug administration, will be continued in the ESPEN framework. Sub-regional pooling of technical resources with linkages to existing regional bodies and the creation of multi-country and multidisciplinary research teams is expected to address some of the cross-border treatment and transmission issues which have eluded APOC. The ESPEN institutional framework will safeguard the best of APOC's tried-and-tested features and include both management and technical review capacities, with adequate representation from countries, donors, nongovernmental organizations and communities. Likewise, it is intended to maintain and, where appropriate, enhance APOC's partnerships. The wealth of data from decades of OCP and APOC onchocerciasis control work will need to be captured and safeguarded through digitization, which will require special provisions for this activity to continue in Ouagadougou beyond the formal disestablishment of APOC.

2.7.8. The closure of an important and successful disease control programme such as APOC and its continuation through another, newly-created project obviously represents a formidable learning opportunity for the whole Organization and the experience gathered in this process is expected to be of the utmost value in informing similar initiatives within WHO in the future, in particular how to safeguard the accumulated experience of the old programme, while drawing the right lessons from this experience to improve the arrangements of the successor programme.

Section No.	Recommendation	Management Response	Key Actions	Time Frame	Responsible Unit(s)	Status	Comments
7.2.4	**Recommendations for WHO, NTD stakeholders and donors**						
16	A careful assessment of the requirements for elimination of onchocerciasis in Africa should be conducted. This would include human, financial resources and organizational as well as political will. The recommendations would need to include changes in the approaches needed for elimination rather than just ramping up MDA. This may exceed the transitional capacity of ESPEN, so an alternative approach may be needed.	Will be part of ESPEN and PC activities implementation during 2016 and subsequent years					
17	Trust funds will continue to be an important funding mechanism for onchocerciasis and NTD programming. With the changes in the World Bank trust fund policies, the option of basing this fund at WHO HQ should be investigated.	WHO fiduciary fund dedicated to ESPEN established					
18	In encouraging countries to provide financial contributions to programme implementation, a counterpart, conditionality funding approach might be considered or other alternative approaches to financing. This could be clearly mentioned in the memorandum of understanding with countries and enforced where implemented. Donors should be encouraged to support the integrated package of NTDs, however disease-specific programming needs will continue to exist in some countries.	Taken into consideration into the ESPEN framework.Will be part of ESPEN and PC activities implementation during 2016 and subsequent years					
19	Considering all APOC's many financial, technical, and logistic contributions to disease control, over the last two decades, there are many concerns among national programs regarding the future of onchocerciasis control. National programme managers should be sensitized on the upcoming ESPEN and communicated their shared responsibility to support control and elimination activities, with a clear understanding about what can be and cannot be expected from ESPEN.	Taken into consideration into the ESPEN framework					
20	Development of novel approaches for mass drug administration and interventions against NTDs in urban areas should be encouraged. This is relevant for The Republic of Congo (Brazzaville) where urban transmission occurs, and where there is an influx of migrants with onchocerciasis symptomatic or not, but who could help sustain infection moving back and forth into foci where control is being achieved.	Will be part of ESPEN and PC activities implementation during 2016 and subsequent years					
21	WHO country offices should continue making National Professional Officers available to national and provincial NTD offices to help build capacities in programme management, where there are needs.	Taken into consideration into the ESPEN Transitional Plan of action					
7.2.5	**Recommendations for ESPEN**						
22	ESPEN should begin with a detailed country-by country situational analysis of onchocerciasis. Maps still used in some countries are 20 year old REMO morbidity maps and do not consider the substantial population movements in places, and ecological changes which have occurred in subsequent years. Based on this situational analysis, realistic efforts can be made to address treatment priorities, assistance priorities and research needs. Ex-OCP countries should be included.	Ongoing with a rapid desk review analysis conducted, ESPEN induction workshop and upcoming ESPN country missions					
23	Building on these data, ESPEN should establish a result-based management approach with the capacity to measure outcomes in the way APOC could not.	Taken into consideration into the ESPEN framework					
24	At the same time, a careful inventory of country and regional level technical resources for onchocerciasis elimination needs urgently doing. Hopefully many of the assets created by APOC can be captured.	Part of APOC administrative closure documents. Also taken into consideration by a desk review analysis conducted					
25	ESPEN should follow the APOC practice of strengthening health services including human resources, rather than just utilizing existing health services for delivery of MDA. To do otherwise would be unethical.	Taken into consideration into the ESPEN framework					

Section No.	Recommendation	Management Response	Key Actions	Time Frame	Responsible Unit(s)	Status	Comments
7.2.4	**Recommendations for WHO, NTD stakeholders and donors**						
26	ESPEN should promote the sub-regional pooling of technical regional resources for epidemiological and entomological evaluation and for decision making to support field activities. Building of multi-country and multidisciplinary research teams focusing on perations research can inform regional implementation. This may address some of the cross-border issues which have eluded APOC. Sub-regional teams have the option of capturing some of the human capacity created by APOC. Linkage with existing regional bodies is important for this including the African Union new African Centres for Disease Control and Prevention. Links with regional economic bodies may facilitate a better understanding of the socioeconomic impacts on onchocerciasis along with the other NTDs.	Taken into consideration into the ESPEN framework					
27	Governance structures must include both management and technical review capacities. Adequate representation from countries, donors, NGDOs and communities is important. The regular governance functions of APOC were widely appreciated and should be continued as relevant. The partnerships developed through APOC should be maintained and enhanced where possible and appropriate.	Taken into consideration into the ESPEN framework					
28	Loiasis is a complex issue that will prevent some countries and zones from achieving elimination in a timely manner, but was managed carefully by APOC. The difficult decision making and careful attention to data must not be discarded by ESPEN in pursuit of a light and flexible structure. To do so will put persons at risk of serious events. There are many difficult decisions required in this and other aspects of ivermectin MDA which requires considered judgement by pooled expertise.	Will be part of ESPEN and PC activities implementation during 2016 and subsequent years					
29	Cross-border treatment and transmission issues will need to be addressed more aggressively not only for onchocerciasis but for other NTDs as well.	Will be part of ESPEN and PC activities implementation during 2016 and subsequent years					
30	APOC was creator and repository of much of the history of onchocerciasis in Africa. There is still an important need to capture the decades of data from OCP and APOC. It is unlikely that all will be digitized by the end of APOC and special provisions should be made for this activity to continue in Ouagadougou until the work is complete. There is also a library of specimens to be archived in an accessible manner.	Currently being addressed as part of ESPEN roll-out.					
31	Fragile and conflict-affected states endemic for onchocerciasis continue as a problem in the region. ESPEN should examine innovative approaches for sustaining MDA in unstable states and among populations displaced by conflict from these regions.	Will be part of ESPEN and PC activities implementation during 2016 and subsequent years					

2.8. Keeping Countries at the Centre: Assessment of WHO's Performance of its Roles and Functions in the Pacific; and Strengthening Country Support in the WHO Regional Office for the Western Pacific (2014)

2.8.1. These two external evaluations were commissioned by the WHO Regional Office for the Western Pacific as part of a series of assessments to gather evidence on its initiatives in the context of the WHO reform since 2009, which included building on a culture of evaluation. The first evaluation analyzed the delivery of WHO's work in the Pacific, as the sub-region's 21 island States and areas are scattered over the world's largest ocean, thus requiring a unique response. The second evaluation was done in response to a specific recommendation in a 2012 review to "assess whether the Regional Office is really country-focused".

2.8.2. The first evaluation reviewed the performance of the Regional Office's roles and functions in the Pacific, the role of its Division of Pacific Technical Support, its relations with other WHO offices and stakeholders, and its added value for achieving better results at the country level. The approach of the second evaluation focused on building on and helping to implement recommendations made previously in various reports and documents produced as part of the reform effort, based on a desk review, interviews and focus group discussions, in order to document and prioritize a large number of proposals for future change. The second evaluation produced an outline implementation plan with specific actions, responsibilities and time frames which contributed to the development of the Regional Office's new reform initiative "Keeping Countries at the Centre".

2.8.3. In 2014, senior management in the Regional Office reviewed the findings and recommendations of the two evaluations together with other relevant assessments. In addition, recommendations from external evaluations were considered, including the Review of Management, Administration and Decentralization in the World Health Organization by the Joint Inspection Unit of the United Nations System, and the Multilateral Organization Performance Assessment Network: Institutional Report: World Health Organization (the "MOPAN" review, 2013). Inputs from the Regional Office and country offices, including deliberations at the 106th Consultation of WHO Representatives and Country Liaison Officers (Manila, 24-28 March 2014), have also been incorporated.

2.8.4. The main lessons drawn from these evaluations relate to the continual evolution of the way WHO works. Although the Organization's mission has not changed and its headquarters must take a broad global view, focus at the regional level must be sharply attuned to the needs of their respective Member States and country offices. The Regional Office needs: to take stock so as to assess to what extent the regional reform agenda has achieved its objectives; and to provide feedback in order to deal with unfinished reform actions, while continually reprioritizing in order to meet emerging challenges, building on success stories and achievements to date.

2.9. Accelerating Nutritional Improvements in Sub-Saharan Africa (2015)

2.9.1. The purpose of this evaluation, which was carried out by an independent external evaluation team, was to assess the relevance and performance of the Accelerating Nutritional Improvements in Sub-Saharan Africa (ANI) project, which ran from 2012 to 2015 and supported 11 countries in their efforts to improve the nutrition status of women and children, in particular by helping countries build sustainable national health information systems. The evaluation fulfils the dual objective of accounting for the investment of its main donor, at whose request it had been commissioned, as well as providing an organizational learning opportunity for WHO on project impact. The project is implemented by the WHO Department of Nutrition for Health and Development jointly with the WHO Regional Office for Africa and respective WHO country offices.

2.9.2. The evaluation concluded that the project was successful, highly appreciated by all its stakeholders, and, for some of its target countries, the only project dedicated to strengthening the country's nutrition surveillance system. Although the project's duration had been too short to result in sustainable impact as yet, it had fostered partnerships to improve programming for nutrition surveillance, contributed to national ownership of the nutrition agenda and to reinforced country capacities in this field. Key recommendations related to the end-of-project strategy, audit and other transition arrangements, all of which were accepted by WHO.

2.9.3. Specifically, a no-cost extension of the project was recommended to complete ANI, thus making it possible to measure concrete outcomes in the targeted communities, facilitate the establishment of monitoring and supervision of district health centres and community health facilities and to promote the approach further with partners and other donors. A nine-month no-cost extension has since been granted by the donor. WHO and the ANI country offices are in the process of developing a sustainability (end-of-project) strategy to ensure that the project's results will sustain and that WHO can mainstream the key project activities in the regular planning and management of the country offices involved.

2.9.4. The WHO Department of Nutrition for Health and Development is leading an organization-wide effort to develop a nutrition strategy and a business model for its delivery, with the aim of sustaining the nutrition expertise WHO has been able to attract thanks to the ANI project and increasing the operational capacity of the Organization to deal with nutrition issues. The modalities and organization of the mandatory end-of-project audit will be defined together with the WHO Office of Internal Oversight Services, in consultation with the WHO Office of Compliance, Risk Management and Ethics.

2.9.5. In its management response, the Secretariat stated that the evaluation report had been distributed to donors and project partners. The country work plans had meanwhile been revised. Key lessons derived from this exercise were the importance of continuous engagement with government authorities and partners and of a renewed focus on addressing the managerial challenges of implementing a project across the three levels of the Organization.

Section No.	Recommendation	Management Response	Key Actions	Time Frame	Responsible Unit(s)	Status	Comments
1	**No-cost extension of the ANI program** That WHO pursue its activities with a no-cost extension given by DFATD between six months and one year. - That the ANI Country offices analyze their remaining financial needs and plan their activities according to their priorities, supported by dedicated staff in HQ and the Regional Office. - It is highly recommended to complete ANI, making it possible to measure concrete outcomes at the level of targeted communities and to promote the approach with partners and other donors. The remaining funds primarily concern the scale-up component, and although the scale-up activities aren't part of the usual WHO-programme, they are considered key to fostering sustainable changes in the practices of the target groups. WHO should be enabled to complete properly this pilot initiative. That extension would also facilitate the establishment of monitoring and supervision of districts health centers and community health facilities, which are supported to ensure improved quality data control.	WHO agrees with the recommendations	Discussion with the regional and country teams and assessment of the country workplans and available resources (HQ/NHD; AFR/FRH); Discussion with donor and request for a no cost extension (HQ/NHD)	Oct-15	HQ/NHD; AFR/FRH	Completed	DFATD has granted a nine month no-cost extension
2	**Sustainability strategy** That WHO develops a sustainability (end-of-project) strategy to ensure that the Project's results will sustain. - That the ANI Country Offices prepare an end-of-project strategy, and incorporate key nutrition-related support to the Health ministry in their core workplan, supported by dedicated staff in HQ and the Regional office. - For the remaining period of the ANI-project WHO should mainstream the key project activities in the regular planning and management of the country offices involved. WHO should also utilize its procurement experts and financial controllers in the countries and / or region to apply principles of financial orthodoxy and bridge observed capacity gaps (e.g. procurement). - ANI is a project that has successfully fostered attention for nutrition within WHO at all levels, and has increased the operational capacity of the organization to deal with nutrition issues. WHO's Nutrition Department should therefore develop a plan to sustain the nutrition expertise the WHO has been able to attract thanks to the ANI-project. A reactivation of the Project Steering Group could be helpful in this respect.	WHO agrees with recommendations 1 and 3. Recommendation 2 is a lower priority, as most procurements have been implemented	Discussion with the regional and country teams and agreement on sustainability crietria (HQ/NHD; AFR/FRH); Development of country sustainability plans (WHO/NHD); Preparation of managerial options for sustainability to WHO senior management (HQ/NHD); Convening of a Project Steering Group meeting	Juy 2016	HQ/NHD; AFR/FRH	In progress	HQ/NHD is leading on an organization-wide effort to develop a nutriiton strategy and a business model to deliver it. This will be complemented by an assessment of the capacities of WHO staff and the development of recommendations to WHO senior management.
3	**Standard Operational Framework for Project management** That WHO develops a Standard Operational Framework for Project management, particularly for projects such as ANI, cross-cutting all the layers of the organization. - A Standard Operational Framework for Project management provides guidance and rules to project teams on roles, responsibilities and the way of doing, with regard to project preparation; financing agreement; contract management; procurement and financial management; technical and financial reporting; monitoring and supervision; auditing, and project closing. - Anticipating such a framework, the ANI Award Manager should further develop and finalize the Standard Operation Procedure for the ANI-project, and discuss this with WHO Management. This SOP should also include guidance on the interplay between Geneva and the Region (ROs and Cos) for projects with both global and regional elements. The finalized SOP for ANI could form the basis for a general Standard Operational Framework for Project Management. - That ANI Country Offices evaluate their current practices with respect to the management of externally financed projects and provide input to the development of a Standard Operational framework.	WHO agrees with the recommendations	Review the application of the SOP developed for ANI (HQ/NHD; AF/FRH); Submit the SOP to HQ/PRP for discussion (HQ/NHD)	Oct-16	HQ/NHD; AFR/FRH	Not started	
4	**Audit** That WHO uses its own auditing rules to organize the mandatory end-of-project audit. - Both an internal or external audit is possible, but we recommend organizing an independent external financial and management audit at the end of the project, because of the magnitude of the project, but also because such an exercise will produce useful guidelines for an operational framework for project management.	WHO agrees with the recommendation	Request IOS to perform a financial audit	Oct-16	HQ/NHD;	Not started	The modalities of the audit will have to be discussed with CRE and IOS
5	**Gender considerations** That WHO continues integrating gender considerations into nutrition programming. - Considering the high impact of cultural norms on nutrition issues, ANI programming that addressed gender issues, for instance by crafting specific training for men, gave positive results and should be promoted.	WHO agrees with the recommendation	Request GER to review ANI reports (HQ/NHD)	May-16	HQ/NHD	Not started	

2.10. FAO/WHO Project and Fund for Enhanced Participation in the Codex Alimentarius Commission (Codex Trust Fund) (2015)

2.10.1. This external final project evaluation was stipulated as a requirement in the founding Codex Trust Fund project document in 2003 and commissioned by the FAO/WHO Consultative Group for the Trust Fund. Its purpose was to evaluate the functioning and results of the Codex Trust Fund after ten and a half years of its twelve-year lifespan. Overall, the evaluation concluded that the Codex Trust Fund had been successful at fulfilling its primary mandate of widening participation of developing and transition-economy countries in the Codex Alimentarius Commission (CAC), with a vast majority of participants being satisfied or very satisfied with their participation. Its detailed results helped to inform discussions in FAO, WHO and among Codex Member States on possible future measures to enhance further effective participation in Codex by developing and transition-economy countries.

2.10.2. The first Codex Trust Fund (CTF1) ended in December 2015, as foreseen in the founding project document. It was replaced by a successor initiative (CTF2) which came into being on 1 January 2016 and will run for twelve years. CTF2 was designed and developed taking into consideration the findings and recommendations of the final project evaluation of CTF1. The evaluation recommended that a Codex promotional and engagement strategy be developed with the Codex Secretariat to advocate for national support for Codex programmes, promote country participation in Codex processes, and raise the priority and profile of food safety within WHO and FAO themselves, which would make it easier to argue for more support at the national level. In response to this recommendation, CTF2 is linking its communications to the Codex Communications Strategy which was prepared by the Secretariat of the Codex Alimentarius Commission and was discussed and revised at the 38th session of the CAC. Various messages on CTF2 have been prepared for the 39th session of the CAC (June 2016), including informational and fund-raising flyers.

2.10.3. It was also recommended that CTF2 include a built-in iterative planning process that would allow for timely adjustments to project scope and objectives to accommodate changes in the operating environment and evolving eligible country needs and priorities, something that had been more difficult during the twelve-year time span of CTF1 with its relatively rigid framework. Such a process forms part of the founding project document for CTF2, with a first periodic review to take place within three to four years after the start of CTF2 in January 2016.

2.10.4. Other recommendations related to improved financial reporting, cost analysis, and monitoring and evaluation, such as presenting year-by-year comparisons, better cost definitions, a clearer indication of programme support costs (overheads), a more accurate collection and reporting of the level of in-kind contributions being expended on the CTF, and the development of a results framework with objectives that are specific, measurable, achievable, relevant and time-bound. They were either addressed in the final years of CTF1 or have been incorporated into the design and development of CTF2. Beginning with the 2014 Annual Report, annual reports now include a financial reporting table that details expenditures for each calendar year by staff and administrative costs, expenditure by project objectives, monitoring and evaluation costs, and programme support costs.

2.10.5. Further discussions with budget and finance officers in both WHO and FAO are under way to see how the WHO and FAO budget and finance systems can be used to monitor the cost-effectiveness of different implementation approaches without the need to create parallel systems. The new results framework and draft logframe has been included in the founding project document and a new monitoring and evaluation framework is being developed for possible presentation to the Codex member countries in 2017.

2.10.6. The development of better assessment processes for individual CTF-supported delegates and for conditions in participating countries was also recommended and the relevant suggestions have been included in the design of the successor initiative, and figure in the founding project document for CTF2. As CTF2 is further developed based on support to activities requested by eligible countries, assessment elements that may be used include: the mandatory completion of on-line training courses/tests by newer delegates; their pairing with/mentoring by more experienced members or subject-matter experts; and their first-time assessment by these mentors/partners at the end of the meeting, with a report being submitted to their respective countries. For candidate countries, the option of multi-year applications has been created, with flexible packages of assistance to meet the needs of a country or group of countries.

2.10.7. Regarding country needs within the more than 100 eligible CTF countries that can realistically be supported by an initiative such as the CTF, the evaluation recommended conducting further needs assessment and identification in order to obtain a consensus on how to improve the targeting of project activities appropriate to CTF, given the wide range of possible options. In the context of CTF2, WHO and FAO decided to put emphasis on strengthening Codex structures at national level and tailoring support to meet a country's specific needs at a particular time. In some countries (or groups of countries in the case of a group application) this may include increasing the level of knowledge of science and risk assessment in standard-setting and in improving the target countries' skills in understanding the scientific advice provided by WHO/FAO, with a view to improving their scientific and technical input to Codex standards development.

2.10.8. Finally, the evaluation highlighted the need for better alignment of the structure and staffing of the CTF Secretariat with the revised project scope, goals, objectives and activities. More support is required to reinforce FAO and WHO technical contributions to CTF2 work without an unsustainable over-reliance on in-kind contributions of FAO and WHO staff. This is linked to the issue of funding, where strategies need to be developed to increase the predictability of funding, given that the shift to a more tailor-made capacity-building approach intended to impact on institutional capacities will require longer-term funding patterns. In response to this need, WHO and FAO started discussions with donors in 2014 with a view to increasing predictability of funding, obtaining more multi-year contributions and widening the donor base. First advocacy actions were rolled out in November 2015 followed by a meeting on financing in April 2016 and will continue with further consultations with confirmed and prospective donors during the 39th session of the CAC in June 2016.

2.10.9. The main lessons learnt from this evaluation for WHO as a whole relate to: (i) the need for any programme to remain flexible and easily adaptable when running for a long period (twelve years in this case), particularly with regard to its staffing and capacity-

building work in countries in response to evolving needs; (ii) the need for predictable and sustainable funding; (iii) the importance of good monitoring and evaluation practices, including designing evaluation data and other needs into the programme from its inception; and (iv) continuous dialogue with stakeholders as a key success factor for programme management and implementation.

Section No.	Recommendation	Management Response	Key Actions	Time Frame	Responsible Unit(s)	Status	Comments
1	Develop a Codex promotional and engagement strategy with the Codex Secretariat to advocate for national support for Codex programs. This aligns with the Codex Strategic Plan Objective 3 and will help to address the root cause of the factors that impact on the sustainability of developing country participation in Codex. An engagement strategy can consist of various methods. As an example, some respondents indicated that the 50th Anniversary Celebrations of Codex attracted Ministerial level participation from many countries that went a long way to promoting the relevance of Codex and the importance of country participation in Codex processes. There is also a need to raise the priority and profile of food safety within WHO and FAO itself. Conditions at national level are often a reflection of the international landscape and if food safety is not a priority item on WHO and FAO governance bodies it is hard to make a case for it at national level.	Accepted	In light of the Codex Communications Strategy tabled at the 38th session of the Codex Alimentarius Commission (CAC), rather than developing a separate promotional and engagment strategy, messaging that goes out under the implementation of the Codex Communications strategy will be "fine-tuned" with input from FAO/WHO to achieve the aim of securing policy and economic support for Codex activities among policy and decision-makers from key sectors and stakeholder groups.	2015-2019	FOS (for WHO) with FAO and Codex Alimentarius Commission Secretariat	Started	Messaging on CTF2 in Codex Communications Strategy being worked on for 39th CAC. In addition to working through Codex communications strategy, separate discrete communications and advocacy pieces to be drawn up for CTF2. CTF2 informational flyer finalized in November 2015. CTF fundraising flyer to be developed March 2016.
2	Redefine program objectives in light of evolving needs of eligible countries. A recurring theme throughout the findings of the evaluation is that the CTF was a 12-year program and that adjustments were made through-out the period based on ongoing assessments and monitoring. The changes however were limited by the original scope (project document) and were in some cases were slow to be implemented. There is an opportunity at this time, when WHO and FAO are developing a successor program, to ensure that there is a built-in iterative planning process that will allow for timely adjustments to project scope and objectives to accommodate changes in the operating environment, as well as eligible country needs and priorities as they evolve over in the future.	Accepted	Successor initiative (CTF2) has an iterative planning process that allows for timely adjustments through its 12 year lifespan, and the founding document itself can be revisted to ensure that it retains full relevance for the needs of countries throughout the entire period of the successor initiative (2016-2027)	2016-2027	CTF2 Steering Committee consisting of FOS (for WHO) with FAO and Codex Alimentarius Commission Secretariat	Started	Iterative planning process written into founding Project Document of CTF2. First periodic review will take place in 3-4 years after start of CTF2 in January 2016.
3	Improve financial reporting. Year-by-year comparisons should be presented in order to permit comparisons. The costs of any Program Support Costs (overhead), in addition to Project Management and Administration costs, should be clearly indicated. WHO and FAO should make efforts to accurately collect and report on the level of in-kind contribution that is being expended on the CTF.	Accepted	Reporting on Codex Trust Fund is made to all Codex member countries (including CTF donor countries) through annual reports and progress reports tabled at the Executive Committee of the Codex Alimentarius Commission (CCEXEC) and the Commission (CAC). As of 2015, the Codex Trust Fund Annual Report now includes a financial reporting table that details out expenditures for each calendar year broken down into: staff and administrative costs; expenditure by project objectives; monitoring and evaluation costs. Programme support costs for each calendar year are clearly indicated. In-kind contributions from CTF donor countries have also been noted in the 2014 Annual Report. These practices will continue in the future.	2016-2027	Codex Trust Fund Secretariat (located in FOS)	Started in 2015 with new financial reporting in 2014 Annual Report	

Section No.	Recommendation	Management Response	Key Actions	Time Frame	Responsible Unit(s)	Status	Comments
4	Improve the cost analysis of the CTF. There can be better definitions of costs (e.g., what costs are included in training workshops before a Codex meeting, what allowance is made for in-kind contributions) in order to be able to provide cost analysis of project activities. As an example, is a one-day training before a Regional Coordinating meeting cost effective, or is there greater value in a 2 or 3 day workshop? Does pooling DSA for workshops result in cost savings?	Accepted	Discussions currently underway with budget and finance officers in both WHO and FAO to see how the WHO and FAO budget and finance systems can be used to provide cost analysis that can be used to monitor cost-effectiveness of different approaches to implementing activities without creating additional administrative work and/or having to create parallel systems outside the normally used budget and finance systems of the two organizations.	2016-2027	Codex Trust Fund Secretariat, FNM/ACT, & corresponding departments/units in FAO	Started	
5	For effective participation, an approach that assesses both the individual delegate and country conditions needs to be in place. For individuals this may include: • First time, newer delegates have to be fully justified in application; • First time, newer delegates must complete online training course (tested); • First time, newer delegates be twinned with/mentored by more experienced members, subject matter experts, or third parties; and • First time, newer delegates should be assessed by mentor/partner at end of meeting and report submitted to country. For countries this may include: • Change the application process: multi-year application available, based on engagement strategies demonstrating consistency and outlining proposed role of CTF support and flexible package of assistance; • For other countries unable to comply with requirements of multi-year funding, their support can be funded based on current application processes; and • Respect your own guidelines. Applications can be too late and not accepted. Applications can be refused for being incomplete or unsatisfactory.	Partially accepted	As 2015 was the final year of CTF1, little could be done to implement this recommendation in the remaining implementation period of CTF1. Suggestions included in this recommendation that were taken on board in the development of the successor initiative include: moving to multi-year applications; flexible packages of assistance to meet the needs of a country or group of countries; engagement strategies with demonstrable outcomes; provision of information on how the proposed role of CTF2 may complement national support and/or other sources of support.	2015-2016	Codex Trust Fund Secretariat with the Consultative Group for the Codex Trust Fund (CTF1)	Completed	All relevant suggestions from this recommendation have been included in the design of the successor initiative and figure in the founding Project Document for CTF2.
6	Undertake an analysis in regards to country needs regarding increasing availability of scientific evidence and develop a clear range of project activities that can be supported by an initiative such as CTF. There is consensus across the project's stakeholders that the provision of scientific data to the Codex process is critically important. There is however, a wide range of opinions on possible areas of intervention for CTF to support this objective. This wide range of opinions indicates that further needs assessment and identification should be conducted in order to better target project activities that are appropriate to CTF. The activities should be realistic given that historically the CTF has over 130 eligible countries and has expended $640,000 over 10 years (from 2004 to 2013) on the overall objective.	Partially accepted	FAO and WHO still see clear needs among member countries in terms of improving their scientific and technical input to Codex standards development - which can include provision of data, but is by no means limited to this. Some of these needs of countries for improving their capacity in this area may be addressed in countries/groups of countries through the CTF2 application process. FAO/WHO may decide that there is a need for further analysis at some point in the future.	2016-2027	FOS (for WHO) with FAO and Codex Alimentarius Commission Secretariat	Started (for provisions built into CTF2)	With regard to the second part of the recommendation to "develop a clear range of project activities that can be support by an initiative such as CTF", in the context of CTF2 a decision was taken by FAO/WHO to put the emphasis on increasing knowledge of science and risk assessment in standard-setting, and ensuring that countries and delegates are skilled in understanding the scientific advice provided by FAO/WHO and bringing scientific knowledge and data to the negotiation process. Any data collection activities supported will be part of a comprehensive and integrated process emanating from the national level through a country or group application, and will be tied to a specific data gap for standard-setting work in Codex.

Section No.	Recommendation	Management Response	Key Actions	Time Frame	Responsible Unit(s)	Status	Comments
7	Better align staffing to project scope. The structure and staffing of a CTF Secretariat will need to take into consideration project goals, objectives and activities to ensure the right balance of capacity and technical competency to meet project objectives, without an unsustainable, over-reliance on in-kind contributions of WHO and FAO staff.	Accepted	Support required to reinforce FAO and WHO technical contribution to CTF2 work through the CTF Secretariat written into the founding Project Document and budget. Staffing needs will be revisted as needed throughout the timespan of CTF2 to ensure that staffing continues to align with project scope.	2016-2027	FOS (for WHO) with FAO and Codex Alimentarius Commission Secretariat	Started with budgeting for additional professional staff in 2016, 2017 and 2018	Further progress on this recommendation dependent on receipt of increased and multi-year contributions from donors.
8	Develop strategies and plans to increase predictability of funding. In the future, if there are shifts of focus to effective participation, and a shift to more tailor-made capacity building approaches that intend to impact on institutional capacities, long-term activities and strategies need to be utilized which cannot be supported with current funding patterns. There is a need for longer-term, more predictable funding. The project has made some progress in this regard but more diverse sources of long-term funding are needed.	Accepted	WHO and FAO implementing actions to increase level of contributions to meet increased needs, obtain multi-year contributions to increase visibility of funding and widen the donor base. Priority actions include: reaching out to development and trade sectors; identifying and working with CTF2 "ambassador" countries; tailored approaches to individual donors; organization of fundraising events including "Call for Action" event (completed in Nov 2015), CTF2 1st Financing Dialogue (April 2016), CTF2 pledging meeting (June 2016).	Began in 2014 and will continue throughout lifespan of CTF2	FOS (for WHO) with internal resource mobilization units and departments (e.g. within cluster and with CRM) and with FAO and Codex Alimentarius Commission Secretariat	Discussions with donors began in 2014. Roll out of first actions to advocate with donors and increase funding and visibility began in Nov 2015.	"Call for Action" event in Nov 2015 to be followed up by a "Financing Dialogue" in April 2016 and a pledging meeting during the 39th CAC in June 2016.
9	Continue development of Monitoring and Evaluation frameworks. The CTF has made commendable progress in developing and utilizing an M+E framework. The framework should continue to evolve and any new results frameworks should also include baselines and targets, with objectives that are SMART (i.e., Specific, Measurable, Achievable, Relevant, and Time-bound).	Accepted	Based on the results framework appearing in the founding Project Document, a log-frame was developed that also appears in the Project Document and an M&E framework will be drafted in 2016.	Began in 2015. Will continue in 2016 with development of M&E framework and establishment of baselines. M&E will continue throughout the lifespan of CTF2 with periodic reviews planned every 3-4 years, an external mid-term review halfway through the implementation period, and a final external project evaluation in 2026.	CTF Secretariat (located in FOS) with the CTF2 Steering Committee and external expertise in M&E	Started	Results framework and draft logframe developed and appear in founding Project Document. M&E framework currently being developed for intenal discussion between Mar-June 2016 and for possible presentation to 39th CAC in June 2016.

Section No.	Recommendation	Management Response	Key Actions	Time Frame	Responsible Unit(s)	Status	Comments
10	Lessons learned and new best practices should be integrated more quickly and with more consistency into the regular project supported activities of the CTF, within the operational realities of the UN and Codex system.	Partially accepted	In CTF1 regular feedback was received from beneficiary countries and donor countries and this feedback was used to identify and implement action for improved management and/or implementation. For example, the CTF Secretariat was strengthened as a management response to feedback and a new Group 4 was created to further ensure the sustainability of participation in Codex of least developed countries and small island developing states as an operational response to the risk of these countries not being able to sustain their participation after graduation from the Codex Trust Fund. With CTF2, FAO and WHO are formalizing the mechanism for continuous dialogue with major stakeholders through the establishment of the CTF2 Advisory Group. Along with the continuous monitoring that will be undertaken using the M&E framework, the Advisory Group will constitute key mechanisms for integration of and action on learning and application of good practices.	2016-2027	FOS (for WHO) with FAO and Codex Alimentarius Commission Secretariat	Not started	

2.11. Global Fund Concept Note Development (2015)

2.11.1. In May 2014, the Global Fund to Fight AIDS, Tuberculosis and Malaria signed for the first time a significant cooperation agreement with WHO to cover the funding gap in technical support to countries preparing concept notes for the Global Fund's new funding model. In the context of this agreement, this independent evaluation was conducted by an external evaluation team between January and April 2015 to determine the quality of WHO's technical support to countries applying for Global Fund financing through the latter's new funding model and to improve this support during the implementation of the agreement. This assessment included analysis of: (i) WHO's short-term technical support; (ii) WHO's role in assisting countries with the overall process of developing concept notes for the new funding model; (iii) WHO's engagement with the Global Fund's Country Coordinating Mechanisms; (iv) WHO's support to countries in identifying and coordinating technical support for the various inputs required; and (v) collaboration between all levels of WHO with technical partners and Global Fund teams.

2.11.2. The review focused its conclusions and recommendations, all of which have been accepted, on four key areas: technical quality and timeliness of WHO support; operational aspects of its execution in terms of level of collaboration, coordination and communication; its impact on the recipient countries; and the external perception of the level of alignment of the support offered with international guidelines and strategies, its effectiveness and efficiency.

2.11.3. A specific recommendation was made to strengthen approaches to execute technical support within the context of the compressed timeline of the new funding model, especially to widen the available pool of consultants; improve their briefing and training; and move towards longer consultancy engagements to provide more continuous support to countries. WHO has already implemented a series of related follow-up actions, such as maintaining updated rosters of pre-qualified consultants; back-stopping of the work of junior consultants as well as of the support provided by WHO country offices by senior consultants and/or WHO regional or headquarters staff; organizing regional workshops and peer reviews for national staff and stakeholders; and preparing joint programme reviews. However, there may be limitations to WHO's support capacity due to a funding gap for the technical support that countries may request, given the lack of clarity so far on what type of cooperation agreement will be concluded with the Global Fund after the current one ends on 30 June 2016.

2.11.4. Another recommendation related to improving coordination, collaboration and communication between WHO, the Global Fund and all their technical partners in order to reduce duplication or gaps in the support provided. WHO and especially its three technical departments most concerned by the three main areas of intervention of the Global Fund, HIV, tuberculosis and malaria, have already taken specific measures to this end, such as preparing technical documentations and briefings for the technical review panels for each review session; holding discussions in the "situation rooms" and at the grant approvals committee with relevant headquarters focal points; participating in expanded core group calls, setting up a joint working group and a steering committee; fielding joint missions in countries; and participation in regional workshops and peer/expert reviews.

2.11.5. Other recommendations related to focusing on technical capacity-building of national programmes and WHO country offices and better communicating what WHO does and the approach adopted for the provision of technical support to countries for the roll-out of the Global Fund's new funding model, with a view to aligning these efforts with the expectations of the Global Fund and global partners. To achieve this, WHO promotes South-South collaboration between developing countries, including the recourse to national institutes and other available centres of excellence or collaborating centres; training of national programme staff and consultants through workshops; and developing an advocacy paper entitled "Making HIV, TB and malaria investments work: how WHO makes a difference at country level" for its partners to better understand the wide scope of its work and support and avoid any misconceptions.

2.11.6. The main lessons learnt with broader significance to WHO 's work globally were that, in the process of implementing the review's recommendations, the collaboration and exchanges between WHO, the Global Fund and other partners have been significantly strengthened. The quality of the concept notes submitted to the Global Fund remained high during the last reviews by the technical review panel. Better understanding of the Global Fund's new funding model and the cooperation agreement have allowed WHO to fit its support better within the compressed timelines of the new funding model, thus safeguarding and enhancing its reputation as a trusted key technical partner of the latter.

Section No.	Recommendation	Management Response	Key Actions	Time Frame	Responsible Unit(s)	Status	Comments
1	Strengthen approaches to execute technical support within the context of the NFM compressed timeline. It was widely noted by national and WHO respondents that one of the most important areas to address is the impact of the compressed timeline of the NFM on the provision of technical assistance. The compressed timeline has had a ripple effect on technical support, creating a supply and demand issue in the Regions and resulting in a Concept Note development driven need to recruit external consultants. Some time delays in fulfilling that demand, and the need for more direct face-to-face and longer engagement with consultants were noted.	The recommendation has been accepted. Some measures already taken are: Maintaining updated rosters of pre-qualified consultants Making available senior consultants and/or WHO staff to backstop work of junior international and national consultants Backstopping of WHO Country Office support by Regional and Headquarter staff Providing training of consultants and WHO staff to bring them up to speed on aspects of NFM Regional workshops and peer reviews for national staff and stakeholders Joint program reviews and JANS Longer consultancies to provide more continuous support to countries - such as in the Ebola-affected countries	Additional measures being explored and in process: Undertake early proactive involvement in updating the NSPs, doing gap analysis, identifying lead consultants - WHO is preparing regional workshops to help support the implementation of the new Global TB, Malaria Strategies and the new ARV guidelines, which will be the basis for the next wave of concept note submissions. Better leverage WHO collaborating centres Better leverage country and regional expertise across regions South-south collaboration (country-to-country capacity building and support)	Prepare to support countries to access their next Global Fund allocation starting in 2017	HIV, TB, Malaria departments, as well as HIS and FWC relevant departments	in progress	There could be a funding gap for the technical support which countries may request, as there is no clarity yet as to what type of cooperation agreement will be done with the Global Fund. This may have an impact of the support capacity of WHO.
2	Improve coordination, collaboration and communication between ALL technical partners. This recommendation involves WHO, the Global Fund and the other technical partners. While coordination, collaboration and communication are good in many respects, improving these between ALL Global Fund technical partners would help to align efforts, and reduce duplication or gaps in the support provided to countries for Concept Note development. This would also greatly enhance interactions between national stakeholders and partners at country level.	The recommendation has been accepted. Some measures already taken are: Discussions in the "situation rooms" - WHO/GTB and WHO/HIV actively participate in these, with HSS focal points. Technical briefings to Technical Review Panel (TRP) - Technical documentations and PPTs are prepared for each review session. Discussions at the Grant Approvals Committee (GAC) with HQ focal points from HIV, TB, Malaria, HSS and/or ADGO/HTM Expanded Core Group calls, Joint Working Group (JWG), Steering Committee Joint missions in countries (e.g. Kenya in Dec 2015, Malawi, March 2016) Participation in regional workshops and Peer/expert reviews	Additional measures being explored and in process: Have consultations between technical partners, WHO, Global Fund on key technical issues followed by coordinated briefing to the TRP on critical technical issues - Four of these meetings took place Better tell the WHO story of value-added to Global Fund and partners - see section 4 with advocacy paper Stronger consultation during country dialogue and planning in the next wave of application More interaction between Regional Offices and Global Fund Regional Managers and country teams - meetings with GF regional managers and WHO regional focal points were organized in the end of June 2015 - and on 8 November 2015 with a WR's working dinner organized with GF senior management. Establish a centralized communication tool to improve coordination among all technical partners (Calendar of technical support missions) - This is being piloted with the action dashboard of the Implementation Through Partnership project that Global Fund is doing with WHO and other partners.	on-going	HIV, TB, Malaria departments, as well as HIS and FWC relevant departments	in progress	
3	Focus on capacity building of national programmes and WHO Country Offices. This recommendation refers to both improving technical capacity of national programmes, as well as that of WHO Country Offices, particularly the Offices in smaller countries. With respect to national programme staff, the requests for greater focus on capacity building were directly linked to the expressed need for long-term technical support from WHO to do so. With respect to building capacity internal to WHO, the recommendations were focused on ensuring adequate orientation to staff on emerging issues and processes that impact the development of Concept Notes at country level.	The recommendation has been accepted. Some measures already taken are: Deploying senior consultants and/or WHO staff at HQ and ROs to backstop work of junior international/ national consultants and WHO COs where required South-south collaboration (country-to-country capacity building and support) Building capacity through training of national programme staff and national consultants - several workshops are organized during Q1-2 2016 like in EMRO on 28-30 March 2016.	Additional measures being explored and in process: Develop a central repository of regionally-based lessons learned to demonstrate the progression of country efforts - The workshop on lessons learned from the Joint TB/HIV concept notes in November 2015 drew a set of lessons learned and recommendations on going forward. Better leverage expertise from centres of excellence and collaborating centres with national institutes	on-going	HIV, TB, Malaria departments, as well as HIS and FWC relevant departments	in progress	
4	Align with expectations of Global Fund and global partners. On whole, Global Fund and partners recommend WHO better communicate what the Organization does and the approach adopted to provide technical support to countries for the rollout of the GF New Funding Model.	The recommendation has been accepted. The Office for Coordination of WHO-Global Fund Partnership, located in the office of ADG/HTM, has developped an advocacy paper "WHO's Commitment to making investments in HIV, TB and malaria work" for partners, Global Fund, bilaterals, nationals to better understand the wide scope of work and support provided by WHO to countries in the HIV, TB and Malaria areas.	Paper in final stages of production	April-May 2016	ADGO/HTM	in progress	

2.12. REACH Initiative (2015)

2.12.1. The Renewed Efforts Against Child Hunger and Undernutrition initiative (REACH) supports efforts to improve governance of country-level nutrition responses for children under five years of age and women. It brings together WFP, which hosts its Secretariat, FAO, WHO, UNICEF, and the International Fund for Agricultural Development (the latter in an advisory role). Activities began in 2008 and were expanded in 2010. This external evaluation covered the years 2011 to 2015 and focused on the role of the REACH Secretariat and the effectiveness of its work in eight of the initiative's 20 target countries. Its summary report was noted by the WFP Executive Board at its second regular session (Rome, 9-12 November 2015).

2.12.2. The evaluation concluded that progress in the countries reviewed had been uneven and the achievements and weaknesses of the initiative reflected the quality of its design and implementation. Its results would require additional investments and efforts to make them sustainable. The initiative had recently also become the coordinating body for the United Nations Network for Scaling Up Nutrition (SUN), which presented both opportunities for greater alignment and risks of the REACH initiative being side-tracked.

2.12.3. Eight detailed recommendations were made for the next phase of REACH, covering its function, vision, strategy and future focus, partnership approaches, theory of change, operational planning, technical assistance, inter-agency collaboration and commitment, funding options and managerial and accountability mechanisms. Some of them will require political decisions to strengthen the REACH Secretariat at the expense of its constituent partners and - in their absence – WHO can therefore not accept them. In response to these recommendations, a draft work plan had meanwhile been developed and discussed in a face-to-face meeting of the REACH Steering Committee.

2.12.4. Specifically, the core function of the REACH initiative should continue to be the facilitation and coordination of country-level nutrition responses, with a strong focus on maintaining its reputation for neutrality. REACH should develop a medium-term vision, strategies and an operating plan for its second phase, which has a five-year timeframe aligned with SUN's timeframe and strategy. The REACH interventions involve both multi-year facilitation services and specialized short-term facilitation and related services for countries meeting specific criteria.

2.12.5. To maintain its neutrality, clear limits should be placed on the time, type of engagement, and resources that the REACH Secretariat dedicates to supporting the United Nations Network for SUN, which the REACH Secretariat now coordinates. All the United Nations agencies forming the REACH partnership have agreed to this approach, while noting that a longer-term presence of REACH may disempower the United Nations member agencies that are natural providers of technical assistance. REACH should proactively explore and develop new funding options and sources for its second phase. Joint resource mobilization should be promoted to enable REACH and the United Nations Network for SUN to receive support from partner agencies without putting excessive pressure on the budgets of their respective nutrition teams and on their existing human resource capacities.

2.12.6. Other recommendations were not accepted by WHO, in particular that REACH should encourage the United Nations Network for SUN to align its focus with REACH's core function of facilitation and coordination and that the next phase of REACH should be based on a thorough re-appraisal of the REACH theory of change, with a view to formulating the new roles of REACH as both the implementer of the United Nations Network for SUN in the field and the provider of support to SUN more generally. WHO considers that it is REACH that should align its functions to that of the United Nations Network for SUN, and not the other way around, as it was established to provide coordination and strengthen the synergies between partners, not to compete with them. Likewise, WHO does not believe that REACH should be the United Nations Network for SUN implementer on the ground. This is actually a collective responsibility of the REACH partner agencies.

Section No.	Recommendation	Management Response	Key Actions	Time Frame	Responsible Unit(s)	Status	Comments
1	The core function of REACH should continue to be facilitation and coordination of country-level nutrition responses, with a strong focus on maintaining and developing its reputation for neutrality. This function should be based on two modes of intervention: one should involve multi-year facilitation services, building on the approach adopted to date; and the other should involve specialized short-term facilitation and related services for countries meeting specific criteria. Continued support at the country level to strengthen facilitation in the SUN countries should recognize that it may be possible to continue multi-annual "REACH-like" engagements in selected countries – subject to full appraisals – but that in other countries the REACH contribution will have to be on a smaller scale, with specific criteria developed to ensure feasibility. REACH's perceived neutrality has allowed it to be effective as a broker among different organizations and entities. To maintain this neutrality, clear limits should be placed on the time, type of engagement and resources that REACH dedicates to supporting the United Nations Network for SUN.	WHO agrees on the recommendation	REACH workplan to be developed accordingly	Mar-16	HQ/NHD	In progress	REACH is a partnership between UNICEF, WFP, WHO and FAO. All organizations have agreed to this approach
2	REACH should develop a medium-term vision, strategies and an operating plan for its second phase, which has a five-year timeframe to align effectively with SUN's five-year timeframe and strategy.This will require: extending the timeframe in existing REACH countries by two more years to consolidate gains and move towards sustainability (Bangladesh, Ghana, Mali, Mozambique, Nepal, Rwanda, Uganda and the United Republic of Tanzania); and adopting a five-year timeframe in new countries from the outset.	WHO partially accepts this recommendation	Recommendation to be developed in new REACH workplan	Mar-16	HQ/NHD	In progress	A longer-term presence of REACH may disempower the UN member agencies, that are natural providers of technical assistance
3	As part of its key strategies for engagement, REACH should encourage the United Nations Network for SUN – which REACH now coordinates – to align its focus with REACH's core function of facilitation and coordination. The network – and REACH'S support to it – would thus have a central mission in mobilizing the technical strength of the United Nations for facilitating scaled-up and effective country-level nutrition responses.REACH's new and additional responsibility as Secretariat of the United Nations Network for SUN provides the possibility of greater alignment between SUN and REACH. There is opportunity and potential risk in the new arrangement. The opportunity lies in the fact that the valuable resources and leveraging power of the United Nations can be used effectively in the nutrition response. The risk is that of side-tracking what REACH has done well and of REACH losing its valuable neutrality. To address this risk, there is a need for clarity on what the United Nations Network for SUN can achieve and for this to align with the focus and mandate of REACH.	WHO does not accept this recommendation			HQ/NHD	Not started	REACH has been presented as a special provider of policy support functions of the UN Network. It is REACH that should align its functions to that of the UN Network. REACH was established to provide coordination and to strengthen the synergies between partners, not to compete with them
4	The next phase of REACH – and further decisions on funding multi-year, country-level interventions – should be based on a thorough reappraisal of the REACH theory of change, which should recognize that the role of REACH is facilitation and related services, rather than technical assistance or support. The new theory of change should form both the role of REACH as the implementer of SUN in the field and its support to the United Nations Network for SUN. It should be broadly disseminated to contribute to better understanding of REACH's role in the overall nutrition environment.The design of any future REACH multi-year intervention should explicitly state and test the assumptions on which it is based and identify the conditions for receiving REACH support. The evaluation identified five conditions for implementation of REACH multi-year programming: i) a senior REACH facilitator should be in-country for a minimum of five years; ii) thorough consultative preparation by and commitment from all parties; iii) plans for supporting immediate start up; iv) financial commitments from United Nations partners to supporting the REACH approach; and v) early work on approaches to sustainability.	WHO does not accept this recommendation			HQ/NHD	Not started	We do not believe REACH should be the SUN implementer on the ground. This is a collective responsibility of REACH partner agencies.
5	To inform the new theory of change, REACH should commission a study of the architecture of technical assistance for scaling up nutrition. The study should include facilitation and identify priority areas for REACH, taking into account the work of other technical-support partners. The study should be used to inform REACH's medium-term plan of action and its strategies for engagement in the coming five years (see recommendations 1–4).	WHO partially accepts this recommendation	Assessment of the technical needs of SUN countries; Development of business model for UN Network/REACH	Jun-16	HQ/NHD	Not started	We have suggested that a project of joint provision of technical assistance to SUN is developed, that builds on the agencies' technical assistance capacities

Section No.	Recommendation	Management Response	Key Actions	Time Frame	Responsible Unit(s)	Status	Comments
6	Participating United Nations agencies should sign a new Memorandum of Understanding with stronger provisions that include strategic decision-making and accountability mechanisms at the most senior level of United Nations agencies; commitment to contributing funding to country-level REACH activities; and commitment to better coordinating their planning, resourcing, implementation and advocacy efforts in the nutrition sector at the country level.Future work to support country-level coordination of nutrition interventions through REACH should be contingent on serious and public commitment at all levels of United Nations agencies to better coordinate their planning, resourcing, implementation and advocacy efforts in this sector. To this end, high-level commitments from agencies need to be matched with commitments to collaboration at technical level, underscoring that this will entail a less agency-centred approach. In the absence of these commitments, there is the risk that REACH will lose focus, waste effort and ultimately fail.	WHO partially accepts this recommendation	Signature of MoU by IFAD	Jun-16	HQ/NHD	Not started	The current REACH MoU has been negotiated in two years, with great efforts. We think it has prevented the Secretariat from acting independently from the agencies. We believe the REACH MoU should be extended to other partners (e.g. IFAD).
7	The REACH partnership should proactively explore and develop funding options and sources for its second phase. Recognizing its recently augmented role regarding the United Nations Network for SUN, it should particularly encourage appropriate financial allocations from member agencies (see recommendation 6), donors and host countries. Funding from host governments should be encouraged as a means of ensuring sustainability in countries where multi-year engagement is foreseen.	WHO partially accepts this recommendation	Development of a resource mobilization plan	Jun-16	HQ/NHD	In progress	REACH/UN Network and UNSCN should be receiving support from partner agencies without putting excessive pressure on the budgets of the nutrition teams and not at the detriment of the human resource capacities of the partner agencies. Joint research mobilization should be promoted. NHD has made proposals.
8	Country-level implementation of REACH should continue to be guided by CIPs and annual plans. However, CIP processes should be revised to ensure maximum leadership and buy-in from all stakeholders. CIPs should also adopt an approach to ensuring that equity and gender issues are part of the country-level work and global advocacy on nutrition. Ensuring that REACH has expertise in gender and equity, establishing incentives for national actions on gender and equity in nutrition, and monitoring progress against indicators are all essential.	WHO accepts this recommendation	Analysing gender and equity approaches promoted by partner Agencies	Jun-16	HQ/NHD	Not started	

3.0 Update on progress in the implementation of recommendations from recent evaluations reported in the evaluation annual report to the 137th session of the Executive Board[4] in May 2015

A summary narrative of progress has been provided in the evaluation annual report to the 139th session of the Executive Board (document EB139/9) of which this document is a supplement.

3.1. Resource mobilization function at WHO (2010)

3.1.1. The objective of this evaluation was to review the current organization and operations of the resource mobilization function in the context of the resource mobilization framework established in 2005 and to provide recommendations to enhance WHO's resource mobilization efforts.

3.1.2. Further progress made in the past year includes the full implementation of the recommendations regarding: (i) the clarification of responsibilities for key custodian roles for maintaining proactive relations with identified main donors within the newly-established Coordinated Resource Mobilization unit, whose portfolio managers are assigned specific donors; and (ii) a regular analysis of the overall funding situation and existing gaps through the Global Resource Mobilization Coordination Team, in close collaboration with the Department of Planning, Resource Coordination and Performance Monitoring and with the support of the category and programme area networks.

3.1.3. Furthermore, the budget ceiling principle has been replaced by the revised budget management policy and standard operating procedures for organization-wide reviews, and the strategic allocation and management of flexible resources, which is guided by the Global Policy Group and managed by the Department of Planning, Resource Coordination and Performance Monitoring. Regular training on resource mobilization is now being provided in regional offices, and the Coordinated Resource Mobilization unit has been working closely with the Department of Country Cooperation and Collaboration with the United Nations System for briefing heads of WHO country offices about the various platforms as well as with the Department of Human Resource Development in staff induction courses. The resource mobilization focal points in regional offices have identified a counterpart in each WHO country office to serve as the coordinator for resource mobilization support requests and information dissemination at the country level.

3.1.4. In addition, the Organization's message to contributors and partners on funds available and funding gaps has been clarified through the updated programme budget web portal, launched in November 2015, and has helped to increase transparency in the context of engagement with contributors, particularly with the financing dialogue. As regards core voluntary contributions, their timing and distribution criteria are now fully transparent, as they are also included in the updated programme budget web portal. Donor profiles are regularly updated with new and more in-depth financial analysis and information on donors,

[4] Document EB137/7.

and resource mobilization objectives and initiatives are adapted accordingly. The profiles are distributed across the Organization twice per year, before the main governing body meetings in January and May.

Paragraph No.	Recommendation	Management Response	Key Actions	Time Frame	Responsible Unit(s)	Status	UPDATE FROM MARCH 15 to MARCH 16
90	**Recommendations on coherence**						
90a.	finalize a global RM strategy and obtain approval for implementation by the Director-General	accepted	DG established in August 2012 a Task Force on Resource Mobilzation and Management Strategies which completed its report in 2013. The report provides strategic directions for WHO. Moreover WHO is currently developing a Resource Mobilization Strategy which will be included in a wider Financing Strategy and which will be presented at the next WHA	2012-2013	DGO/PRP	completed	
90b.	formally communicate the global RM strategy and subsequent related corporate level initiatives to all levels of the Organization, in order to ensure that local strategies are well aligned with corporate approaches.	accepted	see above, this will be applied as part of the Financing Strategy		CRM	in progress	The Secretariat presented at the 138th EB a four-pillar strategy (EB138/42) with regards to the financing of the PB2016-2017 and the remaining challenges. The EB noted the report which will be presented to WHA69. A formal comprehensive strategy should be developed at a later stage when all the necessary elements have been clarified.
90c.	include in RM strategy specific sub-strategies for non-Member States actors (e.g. foundations, private sector, multilaterals) and country-level developments (i.e. One UN, multi-donor trust funds)currently dealt with by PUN and CCO, and formalize communication between PRP/RMS, PUN, as well as with CCO for country-level RM opportunities	non acpplicable	The situation has changed with the development of the Framework of Engagement with Non State Acttors and new department responsibilities				
90d.	establish clear joint action plans with milestones and performance indicators to foster collaboration on high priority RM initiatives across the Organization	partly accepted	A plan of action will be developed for the implementation of the Financing Strategy		CRM	in progress	Through the Global Resource Mobilisation Coordination Team (GRMCT) institutionalized in the 2014, a number of joint activities are conducted including the development of a resource mobilization module to be incorportated in the Global Engagement Management (GEM) tool
90e.	identify categories of donors with different management requirements for the Organization (i.e. varying degrees of central management) and clarify responsibilities of key custodian roles for maintaining proactive relations with identified main donors e.g. responsibilities for staff assigned the principal role as custodian of the "donor relationship" for a defined set of corporate donors	accepted	CRM includes portfolio managers with clear responsibilities by contributors	on-going	CRM	completed	
90f.	integrate the development of an income plan as part of the overall work plan validation process to enable a "reasonableness check review" of potential funding sources and gaps prior to final work plan approval	accepted	this is included in the web portal, with projections up to 2017	on-going	CRM/PRP	in progress	In addition to the financial information included in the webportal, contributor profiles are being reformated, including an engagement plan for each contributors as well as an income plan
90g.	appoint the PRP/RMS Coordinator to drive the implementation of the corporate RM strategy, working with the GRMT to implement agreed actions	accepted	A new "Coordinated Resource Mobilization" unit within DGO is now created and headed by a Director	01-Aug-14	DGO	completed	
90h.	strengthen the role of the SO network clarifying their responsibilities for monitoring funding requirements, identification of gaps and coordinating SO level RM activities across the Organization	partly accepted	This is mainly done through the Global Resource Mobilisation Coordination Team, with the support of the category network (replacing SO network). Funding situation is regularly analysed and plans to fill the gaps discussed	on-going	CRM/PRP	completed	The GRMCT is now fully operational and meeting on a regular basis with face-to-face meetings and monhtly videoconferences. Funding requirements are analysed and reviewed through various tools, including the newly upgraded Programme Budget Webportal

Paragraph No.	Recommendation	Management Response	Key Actions	Time Frame	Responsible Unit(s)	Status	UPDATE FROM MARCH 15 to MARCH 16
150	**Recommendations on effectiveness**						
150a.	review the budget ceiling principle and ensure closer monitoring of implementation of the AGFR's decisions, notably on budget allocations, re-allocations and increases	accepted			DGO/PRP	Completed	The mechanism of AGFR is replaced by the Strategic allocation and management of flexible resources which is goverened by GPG. Budget allocations, reallocations and increases now follow an organization-wide management policy and SOP.
150b.	establish guidelines for the inclusion of related staff costs in programme proposals and step up advocacy efforts towards partners/donors	accepted	The Standard Procedures Donor Agreement End-to-End have been updated to include part of this information, including guidance on cost-recovery and development of budgets for proposals & agreements with donors	?	CRM	completed	This is included in the Donor Agreement End to End
150c.	communicate clearly the timing and distribution criteria of CVC to provide for more predictability and to reflect corporate strategic priorities	accepted	There is now transparency on the CVCA allocation, as it included in the webportal. Moreover the DG has provided regular guidance and communications across the organization	started in 2014	DGO/PRP	Completed	As mentioned in 150a, Strategic Management of Flexible Resources based on agreements made by GPG follows clear principles and distribution
150d.	review the role of SO networks in the strategic distribution of flexible resources among TUs	non accepted	see response for 150.c				
150e.	clarify instructions to TUs on the conditions under which CVC providers may be approached for specific project proposals	accepted	Some communications from DGO, not really in the form of instructions as most CVCA contributors want to provide VC funding as well	ongoing	CRM	in progress	This is part of the wider project mentioned above in reformating the contributors profiles in which contributor specific engagement instructions will be provided to the entire organization
150f.	review and clarify the application of the 70/30 principle according to the nature of departments' technical activities andto the implementation capacities of ROs and WCOs	not applicable	this is now superseeded by the Member States Working Group on Strategic Budget Space Allocation		GMG/PRP	Completed	This proposal is now surpassed by Strategic Budget Space Allocation.
150g.	clarify the Organization's message to donors and partners on the funds carried forward, including the need for a reserve of predictable funds to secure staff salaries and core activities at the beginning of each new biennium, and consider including necessary carry-forward amounts in future budgeting exercises	accepted	this is addressed with the webportal and the financing dialogue	2014	DGO/CRM	completed	
150h.	strengthen the central RM function's mandate and authority to monitor reporting to donors	partially accepted	Reporting will be better coordinated but not necessarily centralized		CRM	in progress	Reporting to contributors will be streamlined through an end-to-end reporting policy currently under development. It will be supported by the GEM tool above mentioned and should improve the quality and timeliness of the reports submitted to contributors

Paragraph No.	Recommendation	Management Response	Key Actions	Time Frame	Responsible Unit(s)	Status	UPDATE FROM MARCH 15 to MARCH 16
197	**Recommendations on efficiency**						
197a.	redefine responsibilities for support of identified major donors through establishing virtual donor support teams led by RMS and drawing on existing RM resources	accepted	will be implemented through the Global Resource Mobilization Coordination Team (GRMCT) and the Global Engagement Management Tool (GEMT)		CRM	in progress	This is being addressed through the GRMCT
197b.	update donor profiles more frequently, develop their content and improve their accessibility to contain more practical donor information, RM objectives on targets, and action plans for current and planned RM initiatives	accepted	the contributors profiles are regularly being updated with new and more depth financial analysis and donor intelligence. They are distributed across the organization	since 2012	CRM	completed	
197c.	define and implement a proposal tracking template to support recording of consistent information and enable periodic consolidation of all initiatives, at least for identifed corporate donors	accepted	a prototype of a proposal tracking tool was developed. This will be integrated in a wider Global Enterprise Management Tool currently in the design phase		CRM	in progress	A proposal tacking module will be included in the GEM tool currently under development
197d.	finalize, in collaboration with HQ/LEG, the development of the clearance procedures for donor contracts, agreements, proposals and reports to encourage standardization and use across the Organization	accepted	A standard WHO template agreement is available for donor who do not have their own template. With other donors, standard framework are negotiated as much as possible	2011	CRM	completed	
197e.	consider the benefits of additional analytical support, such as in the area of operational research to support senior RMS staff with the increasing demands for RM related analytical and donor information	accepted	PWC is conducting a study on broadening the donor base, including an analysis of current and potential new donros. Interns also support this work is done by interns	since 2014	CRM	in progress	CRM is working with interns throughout the year to conduct this analytical work.
197f.	identify a focal point for training within RMS charged to work with PUN/CCO and RO/External Relations units to develop and implement an integrated training programme for WRs and WCO staff	partly accepted	regular trainings are provided in AFRO and WPRO. A proposal for training in HQ for underfunded programme areas has also been submitted to Staff Development and the answer from the Global Learning Committee is still expected		CRM	completed	In addition to the regular trainings reported last year, CRM has been working closely with CCU for briefing WRs in the various platforms as well as with HRD in staff induction course
197g.	identify a RM focal point in each WCO to serve as the Coordinator for RM support requests and the principal contact for RM information dissemination at the country level	accepted	This was done through the regional office resource mobilisation focal points		Regional offices	completed	

3.2. WHO financing dialogue

3.2.1. This evaluation was conducted in line with decision WHA66(8) and its objective was to assess whether the financing dialogue and related resource mobilization activities improved the alignment, predictability, flexibility and transparency of WHO's financing and broadened WHO's contributor base.

3.2.2. As the financing dialogue occurs every two years, WHO had to implement the recommendations in stages. The implementation of those recommendations not already reported as accomplished in the last annual evaluation report had already started in the context of the planning and preparation for the subsequent financing dialogue following the evaluation (Geneva, 5 and 6 November 2015). The still unfinished parts of the work will be implemented in its aftermath, taking into account other ongoing initiatives, including the development of a global engagement management tool.

3.2.3. The financing dialogue in 2015 included key performance indicators for the first time. A new resource mobilization strategy has been developed as part of WHO's financing strategy, which was discussed by the Executive Board at its 138th session in January 2016. The financing of the Programme budget 2016-2017 will be further discussed during the Sixty-ninth World Health Assembly in May 2016.

3.2.4. The financing dialogue in 2015 featured an updated version of the programme budget web portal, which provides additional granularity and financial flow to the country level and programme areas. The web portal will be further updated to provide additional transparency, particularly in terms of results reporting. Moreover, flexible funds such as core voluntary contributions, which are also featured in the web portal, are managed strategically, with the Director-General providing regular guidance and communications across the Organization.

Recommendation No.	Recommendation	Management Response	Key Actions	Time Frame	Responsible Unit(s)	Status	UPDATE From March 2015 to March 2016
1	**Align and present WHO's resource requirements in line with global health priorities.**						
	Actions: WHO to undertake a global needs assessment in key areas of action (e.g. PQP polio, communicable diseases, non-communicable diseases) and demonstrate to contributors how WHO intends to address these needs.	Partially accepted	A review of global needs in the health sector was done in the context of the development of the 12th General Programme of Work and approved by WHO Member States		PSD	completed	
2	**Extend the time horizon of the financing dialogue from short term (2 years) to the medium term (6 years).**						
	Actions: Leverage the global needs assessment results to develop an estimation of the medium term of financing needs for discussion.	Accepted	A 6 year horizon (2014-2019) has been introduced in the webportal, which will provide a new basis of discussion with contributors for the Financing Dialogue 2015 and the related preparatory activities	started 2014	CRM/PRP	completed	
3	**Embed the financing dialogue in WHO's resource mobilisation strategy.**						
	Actions: WHO to undertake an assessment of all on-going resource mobilisation activities and create a WHO single RM strategy.	Accepted	A resource mobilisation strategy is being developed, which will be included in WHO's financing strategy to be presented to WHA68	depending on results of WHA discussions	CRM	**completed**	**The Secretariat presented at the 138th EB a four-pillar strategy (EB138/42) with regards to the financing of the PB2016-2017 and the remaining challenges. The EB noted the report which will be presented to WHA69. A formal comprehensive strategy should be developed at a later stage when all the necessary elements have been clarified.**
4	**Make the necessary investments to improve the brand and increase visibility**						
	Actions: WHO is to invest in strategic communication advice and learn from other UN agencies that are strong in outreach.	Accepted	This will be implemented in the framework of the Financing Dialogue 2015, mainly with a new approach to communicate results	starting asap	CRM/DCO	**in progress**	**With the 2015 Financing dialogue release of the PB webportal results have started to be included. During 2016 the system of results reporting will be improved.**
5	**Provide transparency on strategic allocation of CVCA funding**						
	Actions: Determine needs based resource allocation processes and provide transparency on use of CVCA funding.	Accepted	There is now transparency on the CVCA allocation, as it is included in the webportal. Moreover the DG has provided regular guidance and communications across the Organization	started in 2014	DGO/PRP	completed	
6	**Undertake an evaluation of the web portal and take action to improve so that the portal maximises its impact**						
	Actions: WHO to undertake an evaluation of the web portal to inform the strategic use of the portal in the medium and long term.	Accepted	Informal meetings with Geneva-based mission were held in 2014 to receive their inputs on how the web portal could be improved. Moreover the Web Portal 2.0 which will be launched during the Financing Dialogue 2015 will be reviewed in 2016		CRM	**completed**	**The revised webportal was presented at the Financing Dialogue 2015 meeting. The increased transparency with a number of new features such as financial flow from contributors to implementation, details at programmatic and country levels were very much welcomed. In view of the overwhelmingly positive feedback on the webportal the formal evaluation is not focusing on the webportal but on the bilateral meetings.**
7	**Invest in staff capacity to be able to execute a RM strategy and to leverage the full potential of the financing dialogue**						
	Actions: Secretariat to appoint a resource mobilisation Director in HQ who needs to build up a dedicated resource mobilisation team.	Accepted	A new "Coordinated Resource Mobilization" unit within DGO is now created and headed by a Director	01-Aug-14	DGO	completed	
8	**Undertake a mid-term review of the financing dialogue halfway through the biennium**						
	Actions: WHO undertakes a bi-annual Mid Term review and organises a bi-annual Mid Term dialogue in November half way its PB cycle.	Accepted	Kep performance indicators will be included in the Financing Dialogue 2015 plan of action	starting asap	CRM	**completed**	**It was decided to hold the Financing Dialogue meeting every 2 years, just after the approval of the PB by the WHA. However bilateral meetings are held regularly with key contributors and this is being currently reviewed by an external consulting group SEEK**
9	**Make the financing dialogue more inclusive, interactive and focussed.**						
	Actions: WHO to design and implement a more interactive format and carefully identify keynote speakers, from Member States, WHO regions and academia and to tailor the length of the dialogues to their needs.	Accepted	This recommendation will be taken into account during the preparation of the Financing Dialogue scheduled on 5-6 November 2015	Nov-15	CRM	**completed**	**This recommendation was taken into account in the preparation of the Financing Dialogue 2015 meeting which contributed to the success of the meeting**

3.3. Good Governance for Medicines programme (2004-2012):

3.3.1. The evaluation covered the period 2004-2012 and aimed at assessing programme achievements, challenges and lessons learnt, and at contributing to the WHO strategy on good governance in the pharmaceutical sector. Since the last evaluation annual report (document EB137/7), additional funding was received until the end of 2017 which enabled the further development of a technical package on Good Governance for Medicines in line with the recommendations of the evaluation. The programme has meanwhile evolved to support countries in improving governance in an integrated manner, and not only as an independent governance programme.

Section No.	Recommendation	Management Response	Key Actions	Time Frame	Responsible Unit(s)	Status	Comments (2015)	UPDATE From March 2015 to March 2016
3.5.1a	WHO should better explain the focus and value of the instrument with regard to achieving the fundamental GGM requirement of full engagement of all key national stakeholders. This will also require translation into national languages in order to facilitate understanding and effective application.	Accepted	The model framework was revised in 2012 and includes recommendations on involvement of relevant stakeholders. The framework is being translated into French.	Revised framework published in 2014; French version due 04/2015	PAU	Complete		Model framework was translated into French and Arabic
3.5.1b	The GGM Global Advisory Group (GAG) and the GGM technical group should routinely review GGM instruments to ensure that they draw due benefit from other proven pharmaceutical systems assessment methodologies and incorporate improvements based on application in countries.	Accepted	GAG and GGM technical group have been merged and renamed GGM technical working group (TWG). Meetings and teleconferences held to develop technical package.	Meetings: 03/2014 and 05/2015. Teleconferences held throughout.	PAU	Ongoing		This is an ongoing activity. Next meeting planned June 2016
3.5.2a	WHO should promote high-level endorsement and support for GGM by national good governance commissions.	Accepted	High level endorsement is recommended through high level participation in the GGM steering committee as outlined in the GGM framework.	Revised framework published in 2014	PAU, Regional and Country Advisors	Ongoing		Ongoing
3.5.2b	WHO should promote policy and operational linkages between GGM and broader cross-sectoral good governance programmes.	Accepted	WHO collaborates with UNDP who is implementing other sectoral good governance programmes	Ongoing	PAU, Regional and Country Advisors	Ongoing	Potential participation in the cross sectoral governance round table at the International Anti-corruption conference in September 2015	Participation in UNDP meetings in 2015 and 2016
3.5.2c	WHO should promote endorsement and support for GGM at high levels within both the National Medicines Authority (NMRA) and Ministry of Health.	Accepted	Inclusion of governance as a key element of the access to medicines resolution (WHA67.22)	Ongoing	PAU, Regional and Country Advisors	Ongoing		Ongoing
3.5.2d	The WHO Country Cooperation Strategy should include support for strengthening National Medicines Regulatory Authorities (NMRAs) in order to support implementation of the GGM process.	??	Support for strengthening NMRAs is a core funtion of EMP	Ongoing	RHT	Ongoing		Ongoing
3.5.2e	WHO should include the issue of political change resulting in new appointments at senior level in future updates of the Phase II Model Framework in order to stimulate countries to anticipate such changes and identify ways to mitigate the risks that they create.	Accepted	The involvement of various stakeholders in the GGM task force and steering commitees ensures that some key stakeholders remain despite political changes.	Ongoing	PAU, Regional and Country Advisors	Ongoing		Ongoing
3.5.2f	WHO should anticipate the complexity of federal systems or where there has been significant devolution inorder to ensure that all key informants from all levels are included in the Phase I Assessment and are duly represented in subsequent national GGM steering committees.	Partially accepted	The revision of the assessment tool will include revisions on selection of key informants to ensure adequate coverage. It is not possible to include all key informants in the steering committee (there could be as manay as 50).	Revised version expected 09/2015	PAU	In progress		Tool has been revised to include desk research only.
3.5.2g	In countries where the term "corruption" or even "good governance" is resisted or perceived as an issue, WHO should seek a high-level decision on nomenclature during the initial phase of discussion on country participation in GGM.	Accepted	Nomenclature has been discussed with staff from country offices and most agree that the term good governance should be used in order to cover lack of efficiency due to issues beyond corruption such as poor leadership or management.	Ongoing	PAU, Regional and Country Advisors	In progress	This term is now more widely used in the GGM programme.	This term is now more widely used in the GGM programme.
3.5.3a	WHO should give high priority to finalising outstanding GGM documents, including guidelines on GGM monitoring and evaluation in countries. They should include indicators of programme outputs, outcomes and impact.	Accepted	The revision of the GGM assessment tool is underway and will include indicators for monitoring.	Revised version expected 09/2015	PAU	In progress		Revised version is currently under review by EWG
3.5.3b	WHO should actively promote the identification and engagement of appropriate civil society representation in national GGM processes, including membership of GGM steering groups.	Accepted	Training materials to include promotion of engagement of civil society representation	Q3 2015	PAU	In process		Revised assessment tool includes components on participation.

Section No.	Recommendation	Management Response	Key Actions	Time Frame	Responsible Unit(s)	Status	Comments (2015)	UPDATE From March 2015 to March 2016
3.5.3c	WHO support should include risk analysis and identification of the most appropriate location of GGM within country planning and operational mechanisms in order to promote integration where it may be appropriate.	Accepted	No formal risk analysis has been implemented, but WHO support include support for identifying the ideal location of GGM within the country.	2015	PAU, Regional and Country Advisors	Ongoing		Ongoing
3.5.4a	WHO staff at all levels must remain sensitive to changing country contexts in order to decide the most appropriate support to be provided. Even in countries with well-established and strong GGM mechanisms changes may take place that undermine GGM progress. WHO must always have the necessary information and evidence to alert national GGM Steering Committees to the need for adjustments in focus and strategy, and to propose corresponding changes that may be required in WHO strategic, technical and financial support.	Accepted	No specific action taken as this is an ongoing process.	Ongoing	PAU, Regional and Country Advisors	In progress		No specific action taken as this is an ongoing process.
3.5.4b	WHO should acquire the capacities, skills and mind-sets necessary to ensure subtle, facilitative and tactical support to countries at critical points in GGM evolution, in addition to traditional technical cooperation. This will be dependent on careful definition of the profiles and selection criteria that will be the basis for recruitment of appropriate staff.	Accepted	WHO is inceasing collaboration with universities and experts in governance to support staff capacity.	Ongoing	PAU	In progress	Examples include University of Toronto and Transparency International	University of Toronto established as a WCC, process started to enter into official relations with Transparency International
3.5.4c	WHO Country Offices should have authority to provide flexible, small-scale financial support, especially in countries that lack dedicated budgetary provision for GGM activities.	??					This is a Country Office budgetary decision	
3.5.4d	Fulfilling the above tasks may require a WHO officer at country level with full-time responsibility for day to day GGM oversight and management. An alternative solution could be the appointment of a full time national official, from MoH or MRA, with strong backup from the WHO Country Office.	Not accepted	WHO does not have the funding for WHO country level staff with full time responsibility for GGM.					
3.5.4e	In order to promote GGM added value at all levels of WHO, the programme should establish or strengthen operational linkages (a) to other programmes that promote good governance in medicines (such as MeTA) and (b) to wider WHO support in strengthening health systems, where GGM experiences could inform the new focus on good governance. Strengthening national health policy development processes as well as health workforce management and health systems financing are obvious examples.	Accepted	Operational linkages to other access to medicines initiatives within the department have been made.	Ongoing	PAU	In progress		Collaboration with other health systems departments such as health financing and IER is ongoing.
3.5.4f	Unstable WHO funding can undermine both GGM processes in low-income countries that are dependent on WHO funding support as well as GGM inter-country and global activities. WHO should establish a risk assessment process to anticipate such problems and find solutions before damage is done.	Accepted	Efforts have been made to ensure continuous funding. Current funding is available until 2016.	BMZ grant received 2014-2016	PAU	In progress		Additional efforts have been made to secure funding through 2017
3.5.4g	WHO should first seek the advice of the GAG Chair and members in the process of re-establishing a knowledgeable and enthusiastic Global Advisory Group.	Not accepted	The GAG was reorganized to form the GGM Technical Working Group,					
3.5.5a	GGM activities should be fully integrated within the WHO medicines programme at all levels and provided with dedicated, identifiable and sustained funding support. Proper integration will promote greater complementarity between the elements of the medicines programme and add value to WHO support to countries.	Partially accepted	Current funding is available until 2016.	BMZ grant received 2014-2016	EMP	In progress		Current funding is available through 2017
3.5.5b	The good examples of communication, coordination and active cooperation on GGM between WHO/EMP and AFRO, EMRO and WPRO Regional Advisers should be extended to the other regions.	Accepted	Regional meetings have been proposed in EURO, AFRO and WPRO/SEARO to strengthen the collaboration.	Q3 2015	PAU, Regional Offices	In process		Regional meetings were held in EMRO, AFRO and WPRO/SEARO. A global meeting is planned for June with interested countries.
3.5.5c	GGM experiences in countries as well as the GGM methodology should be utilised to inform WHO's new focus on health systems governance. The evaluators welcome the decision to dedicate the latter part of 2012 to consolidating the GGM programme activities, including undertaking this evaluation, in order to learn lessons and formulate a WHO vision for future work on good governance of the pharmaceutical sector.						To be address by Health Systems Governance unit?	
3.5.5d	GGM should remain within MPC, in view of its strong focus on support to countries. It also provides opportunities to increase GGM contacts and improve coordination and complementarity with WHO partners active in work on good governance in medicines. Examples are MeTA, GFHTM and the European Commission	Accepted	Synergies have been established with MeTA and The EC Renewed Partnership programmes	Ongoing	PAU	Ongoing		Ongoing
3.5.5e	With regard to the EC/ACP/WHO Renewed Partnership, GGM methodologies should be applied more widely in participating countries and thereby access the funds necessary to deliver results. Experience from this evaluation suggests that GGM's cost-effectiveness would be an asset in order to deliver improved transparency. Such evidence would serve as a powerful lever for approval of GGM as a core WHO approach in the context of WHO reform.	Accepted	One of the EC Renewed Partnership programme deliverables is related to governance.	Ongoing	PAU	Ongoing	Governance has been identified as a key factor for improving access to medicines in the resolutionWHA67.22	Ongoing

3.4. Advancing sexual and reproductive health (2008-2012):

3.4.1. The UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research training in Human Reproduction (HRP) is subject to periodic independent external evaluations, to ensure its effectiveness and efficiency in executing its mandate.

3.4.2. Since the last evaluation annual report, further progress has been made in improving the Special Programme's reporting mechanisms by clarifying the results it achieves, as distinct from the results achieved by programme development in reproductive health. A "HRP Alliance" was formed through which the Special Programme aims to enhance the involvement of research centres of programme countries in its "global" research agenda. A new communications and advocacy strategy is being developed with the help of a leading communications firm, which will aim, inter alia, at strengthening the uptake of guidelines and evidence in countries. Finally, arrangements for engagement with cosponsors have been extensively revised, in order to enhance engagement for the achievement of mutual goals, with a focus on the Sustainable Development Goals and those in the United Nations Secretary-General's Global Strategy for Women's and Children's Health.

Section No.	Recommendation	Management Response	Key Actions	Responsible Unit(s)	Status (March 2015 - Updated March 2016)
8.2.1	**Results**				
1	For future biennia, starting in 2014–2015, HRP should develop a new results framework which, in addition to a simplified approach to quantifying outputs, should identify and monitor utilization of its products in programme countries, and, wherever possible, identify their potential and/or actual impact.	Accepted	HRP developed a new results framework for 2014-2015 which included a simplified approach to quantifying outputs.	HRP	Implemented
2	The Programme should commission a periodic review of the utilization of its products in programme countries, and estimates of their potential or actual impact. Such a review will demonstrate the value of investing in HRP and thus further strengthen its fundraising ability.	Accepted	For 2014-2015, efforts focussed on reporting using the new results framework, which includes output indicators of country utilization.	HRP	Implemented
3	HRP needs to clearly identify in its reporting mechanisms the results it achieves, as distinct from the results achieved by PDRH.	Accepted	Efforts will be made to clarify this distinction in the 2013 reports that will be presented in 2014.	HRP	Implemented
4	In future reporting, HRP should distinguish between peer-reviewed articles generated through its global agenda, and those generated from research-capacity strengthening activities. This would provide more transparency and permit a greater understanding of the impact of the Programme's work at both global and regional levels.	Accepted	The distinction between "global" research and national and regional research is becoming blurred, in particular with the launch of the HRP Alliance, in which HRP aims to enhance the involvement of research centres of programme countries in the HRP "global" research agenda. In addition, "global" research projects may generate locally motivated secondary analyses and publications where appropriate.	HRP	Implemented
8.2.2	**Research**				
1	For its major areas of work, the Programme needs to develop mechanisms for identifying research needs and priorities, as well as planning and monitoring research studies, utilizing external expertise.	Accepted	During 2012-2013 HRP conducted research priority-setting exercises using the CHNRI methodology for maternal and perinatal health, unsafe abortion and family planning. HRP, in collaboration with the Department of Maternal, Newborn, Child and Adolescent Health (MCA) and the Implementation Research Platform conducted prioritization for implementation research in 12 high-burden countries in South Asia and sub-Saharan Africa. In addition, HRP uses its evidence-based guidelines for research prioritization since the knowledge gaps are clearly identified and prioritized by the evidence synthesis and the guideline development groups.	HRP	Implemented
2	HRP needs to strengthen and take a more uniform approach to its priority-setting process, in order to identify those key research questions and knowledge gaps in SRH that are most likely to have an impact in programme countries. Criteria should include: a priority issue for countries furthest from the MDGs and other global targets; likely impact; implementability; sustainability; practicality; cost; risk; comparative advantage of HRP; and lead time.	Accepted	The CHNRI approach mentioned above provides a uniform approach taking into consideration the likely impact of the research questions on (i) impact on health outcomes, inequality and (iii) feasibility of their implementation. However, while it is useful for identifying global (or national) priorities, it does not necessarily provide a practical tool for the Department to select its priority projects. The guideline-driven research priorities are more specific and easier to focus as an HRP-led research or research that can be more easily led by a regional or national partner.	HRP	Implemented
3	For HRP to maximize its potential impact, it needs to strengthen its focus on research questions that will benefit the least developed countries and those furthest from the MDG targets, and, wherever possible, on undertaking this research in these countries. All proposed work should include a clear statement of how it contributes directly or indirectly to the achievement of MDG targets 4, 5 and 6 or any post-2015 global targets. This statement should be used by STAG as a major indicator of the relevance of the proposed research.	Accepted	In identifying research priorities for the Department as well as global research priority setting exercises, this is considered. Additionally, HRP has led global monitoring efforts in some key MDG indicators like maternal mortality.	HRP	Implemented
4	In its overall programme of work, HRP should consider giving higher priority to implementation research, research on adolescents and research on the social determinants of SRH.	Accepted	Adolescent sexual and reproductive health (ASRH) is one of the three topic priority areas in HRP. Progress is made on several fronts, including the preparation of two research proposals for multicountry research on 1) an intervention study for reducing unplanned pregnancies in postpartum adolescents and 2) assessing the effect of an adolescent-specific mobile Health intervention in improving health care use and selected sexual and reproductive health outcomes.	HRP	Implemented

Section No.	Recommendation	Management Response	Key Actions	Responsible Unit(s)	Status (March 2015 - Updated March 2016)
8.2.2	**Research**				
5	The Programme should renegotiate its relationship with regard to the overlapping functions that exist between RP2 and ERC. Ideally, a way needs to be found for WHO senior management to entrust the ethical review of HRP's research to RP2. This will most likely require a number of actions, including investment in a more robust RP2 database with support for data management, and application by RP2 for FWA-OHRP accreditation (Federal Wide Assurance for the Protection of Human Subjects – Office for Human Research Protections Database), which would include a system of periodic external reviews of RP2.	Accepted	Director, HRP, has held discussions with the Assistant Directors-General (ADGs) of the Family, Women and Children's Health cluster (FWC) and Health Systems and Innovation cluster (HIS). To date, the possibility of entrusting ethical review for HRP projects to the RP2 (without WHO-ERC review) has not been accepted by the ADG/HIS. In the short term, in order to improve efficiency and given that WHO is not accepting RP2 ethics review responsibility, the HRP plan is for RP2 to focus on the scientific, technical and financial review, with limited review in ethics. HRP will continue to propose new independent members to WHO ERC with expertise in sexual and reproductive health and rights. The Secretariat of RP2 has completed an informal audit and it was found that RP2 is compliant with FWA-OHRP; thus ready when and if, a decision is made to officially apply for FWA-OHRP accreditation. As required, to ensure privacy and confidentiality, the RP2 database has been updated; and, access to the SharePoint drive is restricted.	HRP, FWC, HIS.	Implemented
6	In order to gain further efficiencies, the Programme may need to re-examine the balance between the proportion of research being done by programme staff and the proportion being managed by programme staff but implemented by outside institutions.	Accepted	With the launch of the HRP Alliance, which aims to enhance the involvement of research centres of programme countries in the HRP "global" research agenda, this traditional balance of funding may need to be revisited. Increasingly, collaborating centres are taking a regional coordinating role in research projects. Selected multicentre projects will be completely coordinated by regional centres. This approach was used in the past but not systematically.	HRP	Implemented
7	The Programme needs to continue to increase the level of involvement of researchers from programme countries.	Accepted	This will be an integral part of the HRP Alliance.	HRP	Implemented
8	When submitting research proposals to RP2 for final assessment and approval, programme staff should ensure that the proposals are complete and conform to the required technical and scientific standards.	Accepted	The majority of projects being submitted to RP2 by the Programme Staff for the 2013 November meeting have conformed to the needs of the new HRP application forms, and once approved, are meeting a high technical and scientific standard.	HRP	Implemented
9	In addition to the regular annual review of ongoing research proposals, programme staff should consult RP2 at any point after a research proposal has been approved, if any scientific, technical, ethical or management issues arise during the lifetime of the project until its completion.	Accepted	The majority of programme staff involved in research project development and management, have been actively communicating with the Secretariat of RP2.	HRP	Implemented
10	HRP should consider developing an e-platform to enable organizations engaged in research on SRH to share information on their current work and future plans.	Accepted	HRP already uses e-platforms to communicate with its research and collaborating centres. This form of communication will be enhanced under the HRP Alliance. In addition, the new communication strategy will consider new approaches for using e-platforms, including the social media.	HRP	Implemented
11	There is a need for a more formal mechanism for coordination of research between HRP and MCA, particularly in the areas of maternal and perinatal research, and research on adolescent SRH; and between HRP and TDR on implementation research.	Accepted	It is agreed following discussions between RHR and MCA that MCA does not carry out research in adolescent SRH and maternal and perinatal health. In areas of overlap such as intrapartum care, RHR and MCA are collaborating on projects such as the HRP-led BOLD (Better Outcomes in Labour Difficulty) project.	HRP; MCA; TDR	Implemented
8.2.3	**Finance**				
1	All donors to HRP should reflect on the importance of providing the Programme with undesignated funding, and, wherever possible, provide such funding on a multiyear basis. Where this is not possible, the current practice of providing designated funds for specific items of HRP's already approved workplan and budget should continue. The Programme should explore the possibility of additional funding from new foundations located outside the United States of America (USA).	Accepted	HRP is actively engaged with potential new donors, including new foundations located outside the United States of America.	HRP	Implemented
2	HRP needs to continue to build on the success of its resource-mobilization work and strengthen it further by demonstrating and communicating the utilization of its products in programme countries, their potential impact, and how this helps the achievement of global targets in SRH.	Accepted	HRP is developing a new brochure to support resource-mobilization work, which will include communicating the utilization of its products in programme countries, their potential impact, and how this helps the achievement of global targets in SRH. The brochure will be issued in 2016.	HRP	Implemented

Section No.	Recommendation	Management Response	Key Actions	Responsible Unit(s)	Status (March 2015 - Updated March 2016)
8.2.4	**Communication and utilization**				
1	There is a need for HRP to develop and invest in a new communication strategy, which explores innovative ways of packaging and disseminating HRP's research findings and other products for use in strengthening national SRH policies and programmes. The strategy should consider the role of knowledge intermediaries and gatekeepers of change, and that different products will require very different approaches. Subsequent communication workplans should identify clear deliverables and associated indicators.	Accepted	In view of this and other PCC recommendations relating to communications, HRP strengthened its communications and advocacy work in 2014-15. As a first step, after a very competitive request for proposals, HRP engaged a global communications agency Grayling to support the development of the HRP communications and advocacy strategy. Grayling has previously worked with the UN system on a number of successful projects, including the WHO perception survey which was carried out in 2012. The outcome of this project was a new communications and advocacy strategy for HRP in 2014-2016, as well as a detailed implementation plan which identifies, prioritizes and plans for a limited number of key opportunities, events and platforms for 2014-2016.	HRP	Implemented
2	HRP needs to develop, invest in, and implement a strategy for the utilization of its key products in a limited number of countries, to demonstrate their potential or actual impact, and to thereby leverage and guide use of the funds of national governments, cosponsors, bilateral agencies, CSOs, foundations and others, in their support to national SRH programmes.	Accepted	A specific area of work, aiming to introduce evidence-based guidelines including those developed by HRP in countries, was developed and is being implemented in 2014-2015 in the context of the Sida grant to H4+. • WHO guidelines such as postpartum haemorrhage prevention and management, pre-eclampsia/eclampsia and OptimizeMNH are part of UNCoLSC (UN Commission on Life-Saving Commodities) and some countries have independently approached the Department (Kosovo, Mozambique, Myanmar) for support in adapting and adopting selected recommendations. • As part of the Muskoka Grant, during 2013, WHO's family planning training resource package was introduced in ten Francophone Sub-Saharan African countries and the Department has been approached by several countries (Burkina Faso, Côte d'Ivoire) to further adapt the training to meet the needs of providers in their settings. Plans are underway to undertake regional and country-level implementation activities, with linked monitoring and evaluation follow-up, once the revised MEC (Medical eligibility criteria for contraceptive use) and SPR (Selected practice recommendations for contraceptive use guidance) documents are issued in early 2015.	HRP	Implemented
3	The PCC will need to provide guidance on the source of funding for HRP's communication and utilization work.	Accepted	A critical aspect of the new HRP communications strategy will be a focused implementation plan for 2014 which will identify, prioritize and plan for a limited number of key opportunities, events and platforms for 2014. HRP will be able to implement this with current sources of funding. In this regard, it is noted that communications, dissemination, and uptake is now routinely included in project budgets submitted to donors for funding.	HRP	Implemented
4	HRP donors and cosponsors need to review and strengthen their systems and processes for utilizing HRP's products in their own programmes of development assistance.	Accepted	HRP is actively working on this with cosponsors and donors with the aim of increasing the utilization of HRP's products.	HRP	Implemented
8.2.5	**Governance and cosponsorship**				
1	HRP and the cosponsors need to strengthen their engagement, developing clear plans and mechanisms to use the programmatic experience and networks of the cosponsors to help identify key research questions and needs for policy, programmatic and technical guidance, and to use their programmes and networks to promote and expand the use of HRP's products in countries. A progress report should be presented to PCC after 2 years. The Programme should, somewhat cautiously, explore additional cosponsors.	Accepted	The Secretariat will prepare such a report in 2016, in consultation with the cosponsors.	HRP	Implemented
2	PCC needs to ensure that its agenda gives sufficient space for the discussion of policy, strategic and financial issues central to the well-being, growth and development of the Programme, as well as receiving reports on progress, outcomes and impact.	Accepted	The agenda for 2014 has been organized to enable more input from and discussion with participants, and, at the request of PCC, a new results report will be presented.	PCC, HRP Standing	Implemented
3	PCC may wish to consider adding an agenda item every other year that would provide an opportunity for donors, cosponsors and programme countries to report on their use of the Programme's products.	Accepted	The agenda for 2014 was organized to enable more input from and discussion with participants, including donors, cosponsors and programme countries.	PCC	Implemented
4	PCC may wish to consider a number of different options for STAG, including the following: STAG could revert to its original function as the scientific and technical review body for HRP, and could receive and review a report only on the overall work of PDRH on a biennial basis; STAG could undertake in-depth reviews, perhaps in alternate years, of two to three of the main areas of the Programme's work; in other years, it could focus on more strategic, policy and forward-looking issues, as well as reviewing and advising on overall workplans and budgets.	Accepted	The STAG agenda was modified to address this recommendation and to increase efficiency. In 2014, presentations and discussions were spread across three working groups to allow more time and discussion on the scientific and technical aspects of planned and on-going projects in specific areas.	PCC	Implemented
5	HRP should examine the feasibility of merging GAP into STAG. This would require ensuring that STAG maintains adequate gender and sexual and reproductive health rights expertise; carries out biennial reviews of HRP's full programme of work from a gender and rights perspective; and commissions an independent review of its approach to gender and human rights after 5 years.	Accepted	Efforts are being made to increase attention to gender and rights issues in STAG. In 2014, three GAP members were invited to the STAG meeting to inform the discussions by contributing their expertise on gender and rights issues. A proposal will be submitted to PCC 2014 proposing (i) an expanded STAG membership in order to better represent all perspectives on sexual and reproductive health, including rights and gender, and (ii) the establishment of a rights and gender steering committee that will have formal linkages with STAG so that rights and gender issues will be fully integrated within its work.	HRP	Implemented
6	The Programme should consider periodically holding a PCC meeting outside Geneva, but only after prenegotiating a cost-sharing agreement with the host government.	Accepted	Noted. The Programme will explore this and report to the Standing Committee in 2014.	HRP	Implemented