CORE COMMITMENT	RESPONSIBILITIES: 'INDIVIDUAL' (All, Donor or Aid Organisation) or 'JOINT' (All, Donor or Aid organisation)	WHAT ACTION WAS TAKEN IN 2021 TO ACHIEVE THIS COMMITMENT?	WHAT WERE THE RESULTS/OUTCOMES OF THIS ACTION?	WHERE RELEVANT, WHAT RESULTS WERE REPORTED AT COUNTRY LEVEL AGAINST THIS COMMITMENT? (Please specify countries AND results)	HOW WERE CONSIDERATIONS OF GENDER EQUALITY AND WOMEN'S EMPOWERMENT[1] INTEGRATED IN YOUR INSTITUTIONAL EFFORTS TO IMPLEMENT THIS COMMITMENT?	INDICATOR DEVELOPED BY WORKSTREAM CO-CONVENERS	PLEASE REPORT THE REQUESTED DATA FOR THIS INDICATOR
WORK STREAM 1 - TRANSPARENCY							
1.2. Signatories make use of appropriate data analysis, explaining the distinctiveness of activities, organisations, environments and circumstances.	Individual - all	WHO continued to publish on a quarterly basis, qualitative, transparent and harmonised open data on humanitarian funding received, based on IATI standards. Enhancements on more defined humanitarian funding information have been implemented. The ultimate goal is harmonizing the reporting of PAHO and WHO in order to update IATI data Registry on a monthly basis in 2022.	WHO has implemented 15 out of 15 Joint Inspection Unit (JIU) recommendations, by implementing the opened reccomendations n. 6 and n.10. The Organization has been updating its anti-fraud/anti-corruption policies and related strategies and tools (including a corporate fraud risk assessment exercise). The long-standing effort, built on existing anti-fraud strategies, will be codified in a revised policy in 2022 in line with the organizations' risk appetite and enterprise risk management agenda. WHO has enhanced its Business Intelligence functions with additional dashboards to detect fraud. WHO is now in the process of replacing its entire ERP system, including leveraging technology to embed automated internal controls (including anti-fraud detective and preventive controls) in its design.	WHO annually updates the Global Health Expenditure Database (GHED), with data on health expenditure for 192 countries, using available information such as health accounts data, government expenditure records and official statistics. In 2021, individual country profiles have been included, as well as technical notes, methodology guidelines, global, regional, country reports on health expenditure.	Throughout 2021 WHO/WHE invested concerted efforts to develop its first Gender Mainstremaing strategy for the Emergencies Programme (2022-2026). A central objective is to ensure the programme is gender responsive, through the integration of gender analysis across its guidance and strategies. Moreover, WHO continued to support the collection and dissemination of sex disaggregated data, as exemplified by the weekly COVID19 reports issued by the SouthEast Asia Regional Office, and the publication of the Research Brief on using Multidimensional Poverty Index (MPI) in emergencies.	Are you (or any of your affiliates) using IATI data and accessing IATI-compatible data platforms and tools (or different data standards/platforms/tools) in order to enable evidence-informed decision-making, greater accountability and learning? [2] (Yes/no question) Can you expand on your above answer, giving an example(s) of how you use or are intending to use data published via IATI, or when applicable via other data standards/platforms/tools?	Yes, WHO implements IATI by publishing humanitarian operations' information in IATI's agreed electronic format (XML) in WHO Programme Budget webportal, before linking it to the IATI Registry. In order to ensure ease of use and better transparency, each country of operation is reported in a single xml file that can be freely downloaded.
WORK STREAM 2 - LOCALISATION							
2.1. Increase and support multi-year investments in the institutional capacities of local and national responders, including preparedness, response and coordination.	Individual - all	WHO continued to conduct activities to strengthen the operational readiness of countries, WHO country offices and partners for emergencies. WHO supported strategic health emergency risk assessment and mapping in priority countries to guide risk-informed programming to prevent, prepare for and reduce the level of risk associated with health hazards.	WHO is engaging civil society organizations (CSOs) in jointly planned actions to respond to COVID-19 at the local level. WHO is also working on a Strategy for implementing Localization at the field level to assist WHO country and regional offices in identifying, implementing, and sustaining partnerships with local health actors.	20 Country Health Clusters/Sectors out of 29 (69%) have responded to a survey on national NGOs participation in Country Health Clusters/Sectors. Highlights: NNGOs as co-coordinators: only Syria–Turkey Cross-border has a NNGO as co-coordinator. NNGOs as members of the Strategic Advisory Group (SAG): 45% of the clusters have between 1 and 2 NNGOs as part of the SAG.	Under UNFPA's IASC PSEA Championship, WHO contributed to the development of the Implementing Partners Protocol package, to facilitate a coordinated approach to operationalizing the United Nations protocol for preventing sexual exploitation and abuse (PSEA) among non-governmental implementing partners. The coordinated approach is designed to be used for shared partners. Although it is recommended that the UN entities assess their non-shared partners at the same time, each UN entity will undertake those assessments according to their own internal approaches, which may call for a gradual and phased approach. The Implementing Partners Protocol package also includes assessment, scoring and capacity strengthening and monitoring tools. WHO runs monthly interactions with Health cluster coordinators and other leaders in Fragile Conflict-affected and Vulnerable (FCV) countries where the risk	% of partnership or funding agreements that incorporate multi-year institutional capacity strengthening support for local and national responders, with optional reporting on the % awarded to women-led and or women rights' organizations[3]	N/A
2.4. Achieve by 2020, a global aggregated target of at least 25% of humanitarian funding to local and national responders as directly as possible to improve outcomes for affected people and reduce transaction costs.	Individual - all	The proportion of direct funding on the overall budget for the biennium 2020-21 is of 42%. The increase, compared to the previous two-year period (2018-2019) is justified by the funds received and allocated for the response of COVID-19 in fragile and conflict-affected countries.	WHO has been able to ensure a flexible COVID-19 response and to allocate multiyear award to its national/local implementing partners. It has been able to deliver capacity building activities and to work with national and local authorities on improving people-centered public health policies in emergencies.	Out of the 42% of direct funding, 63% have been allocated to the AFRO Region and 33% to EMRO.		% of humanitarian funding awarded as directly as possible to local and national responders, with optional reporting on the % of that funding awarded to women-led and/or women rights' organizations.	42% (2020-2021). PAHO for the American Region is excluded from the analysis.
WORK STREAM 3 - CASH-BASED PROGRAMMING							
3.1+3.6. Increase the routine use of cash, where appropriate, alongside other tools. Some may wish to set targets.	Individual - all	Due to the unique needs and challenges of the health sector, WHO and the health sector are not yet implementing multi-purpose cash as a delivery mechanism. WHO and the Health Cluster did	The Cash Task Team continues to work closely with CaLP, supporting in the facilitating of a regional workshop with the Regional Cash Working Group to outline a learning agenda and workplan for CVA and health activities. This partnership continues as the CTT and CaLP are planning a series of workshops on different topics on cash and vouchers for health outcomes in the early months of 2022	Increased interest in CVA for health outcomes, particularly with the publishing of 3 case studies from Jordan, Burkina Faso and Bangladesh. The Cash Task Team produced a guidance note on assessing the role of CVA for health to reduce barriers to accessing health services and introduces the Tanahashi framework which provides a resource to promote common understanding of barriers related to health services provision.	Throughout 2021 WHO/WHE invested concerted efforts to develop its first Gender Mainstremaing strategy for the Emergencies Programme (2022-2026). A central objective is to ensure the programme is gender responsive, through the integration of gender analysis across its guidance and strategies. WHO participated in the UN Joint Study on the Status of Gender Equality and Women's Leadership in DRR (GEWEL-DRR study), and the development of the implementation framework of the	Total volume (USD value) transferred through cash, transfer value only, excluding overhead/support costs	N/A

	Individual - all	however contribute to cash coordination discussions and develop CVA guidelines within the Global Health Cluster Cash Task Team.	A Survey has been completed in 2021 by 14 Health Cluster Coordinators from Bangladesh, Burkina Faso, CAR, DRC, Iraq, Libya, Mozambique, Myanmar, OPT, Pacific, Somalia, Yemen. (Cash not generally used in the pacific). 50% have declared to have a cash component as one delivery modality.	50% consider cash and vouchers assistance within the response options analysis. In general, CVA is used for patients who require referral to higher level of care. Cash support is provided for transportation, while patients are admitted, and/or as reimbursement of hospital-based procedures or specialized medications/treatments.	Implementation framework of the recommendations emerging from the report. Moreover, WHO continued to support the collection and dissemination of sex disaggregated data to inform decision making and prioritization of emergency preparedness and response strategies, including those of the Health Cluster at country level, and support the integration of considerations of gender inequalities into planning.	Total volume (USD value) transferred through vouchers, transfer value only, excluding overhead/support costs	N/A
WORK STREAM 4 - REDUCING MANAGEMENT COSTS							
4.5. Make joint regular functional monitoring and performance reviews and reduce individual donor assessments, evaluations, verifications, risk management and oversight processes.	Joint - donors					**N/A[4]**	**N/A**
	UN agencies	Within the context of COVID-19 response, WHO Health Emergencies programme continues to work with UN system wide to coordinate the response, covering supply chain, vaccine and other areas. All public and major private sector partners are coordinated via ACT-A initiative and other UN forums.	In 2021, the WHE Data Technology Working Group processed 20 demands for new digital products and continued to validate the relevance of each proposal and its fit with overall WHE strategy. The membership of the group was expanded to include focal points from DHI (District Health Information) for better cross-department visibility on digital initiatives.	All WHO procurement contracts with partners at all three levels (HQ, Regional, Country) outline how risk is shared with the contractor.	WHO continued to support the collection and dissemination of sex disaggregated data to inform decision making and prioritization of emergency preparedness and response strategies, including those of the Health Cluster at country level, and support the integration of considerations of gender inequalities into planning.	# of UN agencies adopting the UN Partner Portal to harmonize UN processes for engaging civil society organizations/non-governmental organizations, and reduce duplicate information reviews/requests of partners.	WHO is exploring the possibility to start using the UN Partner Portal
	Civil society					% of civil society organizations/non-governmental organizations partners of the UN agencies adopting the common UN Partner Portal process.	The reporting responsibility for this specific target is with UN agencies that are using the Portal
WORK STREAM 5 - NEEDS ASSESSMENTS							
5.1. Provide a single, comprehensive, cross-sectoral, methodologically sound, and impartial overall assessment of needs for each crisis to inform strategic decisions on how to respond and fund, thereby reducing the number of assessments and appeals produced by individual organisations.	Joint - all	WHO's work with partners has taken place within the Joint Inter-Agency Assessments Group (JIAG) inter-agency to strengthen the quality of HNOs and multisectoral needs assessments. Specifically, WHO has been expanding its Public Health Information System (PHIS) IM tools, which are being used to strengthen the health component of HNOs/HRPs and the JIAF.	The Global Health Cluster (GHC) continue to provide bilateral technical support to Health Clusters to implement the 2021 HPC. In 2020, the GHC has published a JIAF Indicator Reference Table with Health Indicators. Some require contextualization on the ground, and there is always the option to add indicators as the cluster sees fit.	The GHC plan to finalize a standardized framework and guidance for Rapid Health Assessments (RHA) for which the GHC Core Indicators have been completed. As the work on PiN for the 2022 HNO's concluded, the focus shifted towards applying lessons learned to the PiN Guidance framework and developing it further for the RHA Guidance.	WHO is developing a SEAH risk assessment tool that it will piloted this year to be shared with partners. The Tool integrates existing IASC and agency-specific risk assessment tools and focuses on assessing and addressing SEAH risk in health programmes and health emergency operations that bring WHO and its partners into direct contact with communities. Related training of the WHO workforce and of our partners will be scaled up later this year.	Which challenges have you identified and which actions have you been taking over the past year to strengthen humanitarian needs assessments and needs analysis in field locations and at headquarters? To which extent are these actions contributing to better joint (multi-stakeholders) inter-sectoral needs analysis in the field?	For some sectors, the current means of understanding 'needs' may not actually be appropriate, as a case in point, health cannot look at 'need' in a household/individual retrospective light like most sectors, it must consider a more forward-looking concept of need. There are a few other sectors that may have similar issues.
	Joint - all		WHO/GHC are committed to the coordination of analysis support on health-related matters more specifically, under the scope of GIMAC. They have a strong influence on the sourcing and interpretation of health data and together with UNHCR coordinate the interpretation of health data concerning refugees.	WHO is coordinating data collection through Public Health Situation Analysis (PHSA) specifically to identify the current health status and potential health threats that the population may face, the functioning of the health system, and the humanitarian health response. It is a review of the latest available secondary data. In 2021, a PHSA has been developed on 57% of new graded emergencies.		On a scale of 1 – 10, with 10 being the highest, please identify at what level of priority within your organization you consider the work to support coordinated needs assessments and analysis? What steps has your organization taken over the past year, if any, to ensure the requisite capacity is available to undertake this work.	7/10. There is increasing buy-in from WHO strengthening WHO's assessments capacity in countries.

WORK STREAM 6 - PARTICIPATION REVOLUTION							
6.1. Improve leadership and governance mechanisms at the level of the humanitarian country team and cluster/sector mechanisms to ensure engagement with and accountability to people and communities affected by crises.	Joint -aid organisations	WHO applies accountability and inclusion strategies increasingly into graded emergencies and protracted crisis responses over the past 2-3 years. It also advocates for Needs Assessments to include affected populations. This is the case throughout the health component of HNO/HRPs and for needs assessments conducted in new WHO graded emergencies.	As an example of mechanisms to ensure engagement with the most vulnerable, WHO has been driving the implementation of the IASC guidance for mental health and psychosocial support in emergencies, disability since 2009 and especially again during the COVID 19 response, along with integration of disability and involvement of youth in its COVID 19 and humanitarian response programs.	In a number of emergency responses (e.g Ukraine), WHO has specifically considered accessibility requirements of persons with vulnerabilities, including persons with disabilities, children, young people, women and girls, as well as persons with intellectual or psychosocial disabilities.	Throughout 2021 WHO/WHE invested concerted efforts to develop its first Gender Mainstremaing strategy for the Emergencies Programme (2022-2026). A central objective is to ensure the programme is gender responsive, through the integration of gender analysis across its guidance and strategies. WHO participated in the UN Joint Study on the Status of Gender Equality and Women's Leadership in DRR (GEWEL-DRR study), and the development of the implementation framework of the recommendations emerging from the report. Moreover, WHO continued to support the collection and dissemination of sex disaggregated data to inform decision making and prioritization of emergency preparedness and response strategies, including those of the Health Cluster at country level, and support the integration of considerations of gender inequalities into planning.	**N/A[5]**	**N/A**
	Joint -aid organisations					**N/A[5]**	**N/A**
WORK STREAM 7+8 - ENHANCED QUALITY FUNDING							
7.1.a. Signatories increase multi-year, collaborative and flexible planning and multi-year funding. Aid organisations ensure that the same terms of multi-year funding agreements are applied with their implementing partners[6].	Individual - all	WHO's Health Emergencies Programme currently has multi-year funding agreements with a number of donors. To the best possible extent, WHO is following the rest of the humanitarian community in extending the same practice to its partners. Challenges in capturing cascading funding still need to be overcome.	In 2020, COVID-19 response in fragile settings has brought more multi-year funds and agreements. (Please note that at WHO funds of 12 months of duration are considered multi-year)	113 WHO country offices to which funding from multi-year humanitarian agreements has been distributed.	Gender is a key component of WHO's new General Programme of Work (GPW13), built on the "Three Billions" of beneficiaries that WHO is targeting for improved health outcomes (UHC, emergencies and healthier populations), embodying all gender angles including equal access to healthcare across genders and community contribution to programming.	% of humanitarian funds provided by donors or received by organizations that are multi-year.	77% of funds available are multi-year (received and allocated).
	Individual - all	With the launch of WHO's 2019-23 General Programme of Work (GPW13), WHO has been developing a strategic framework for implementing Universal Health Coverage in Fragile, Conflict-affected Countries that links two of the GPW "Triple Billions" (emergencies and development). This framework will guide multi-year humanitarian planning and funding.	This approach was already being implemented starting 2019, with WHO's Programme Budget and planning cycle revised to receive greater proportions of funding that are multi-year and flexible. For emergencies, WHO is already receiving core funding from different Member States, as well through its Contingency Fund for Emergencies.	This approach will keep be mainstreamed across all levels of WHO: HQ, regional and country.		% change of humanitarian funds provided by donors or received by organizations that are multi-year.	
	Individual - all					% of multi-year humanitarian funding received that is allocated by aid organizations to implementing partners	
8.2. and 8.5. Donors progressively reduce earmarking, aiming to achieve a global target of 30% of humanitarian contributions that is unearmarked or softly earmarked by 2020. Aid organisations reduce earmarking when channelling donor funds with reduced earmarking to their partners.	Individual - Donors					% of humanitarian funds provided by donors or received by aid organizations that are unearmarked/softly earmarked	
	Individual - Aid organisations	In order to improve advocacy actions of unearmaked and flexile funding's impacts on operations, WHO committed to ensure quarterly updates on the allocation of unearmarked and softly earmarked funding through the Programme Budget web portal.	WHO's Programme Budget is financed through a mix of assessed and voluntary contributions. Flexible funds consist of Assessed Contributions, Core Voluntary Contributions and Programme Support Costs. In support of the recognition of the contribution of multiyear, unearmarked and softly earmarked funding, over the years, several donor visibility products have been designed.	Similarily to the Universal Health Care Partnership the delivery of quarterly live monitoring reports and annual progress reports (country, region, global), in which both success and challenges are highlighted (from both a programmatic and a funding point of view), could be envisaged as part of the Grand Bargain.	Over the years flexible funding has enabled WHO to advance gender equity and human rights in health. In order to allow WHO to be more agile and strategic in its investments, videos to calling for an increase in flexible funding arrangements are published in multiple media channels, Twitter, YouTube, LinkedIn, etc.	% of unearmarked/softly earmarked humanitarian funding that is allocated by aid organizations, with flexibility, to implementing partners	8% of contributions is nonearmarked or softly earmarked
WORK STREAM 9 - HARMONISED REPORTING							

9.1. Simplify and harmonise reporting requirements by the end of 2019 by reducing the volume of reporting, jointly deciding on common terminology, identifying core requirements and developing a common report structure.	Individual - all	In 2019, WHO continued to implement the common reporting template for emergency operations in Iraq. Steps were also taken to implement the pilot in Somalia. WHO also revised its revised its standard donor reporting template for emergency funding to incorporate elements of the work stream's proposed common reporting template, in addition to the VFM component mentioned above.	WHO's online programme budget portal was further improved in 2019 to provide even more accessible budget, financing and data on use of donor funds. This re-designed portal version IATI compliant is publishing financial data to the "output" level, which provides a more granular view on WHO activities and how these are funded.	In addition to progressively rolling out the common reporting template in other countries following its successful implementation in Iraq, budget data on all WHO country and regional offices are now fully available on the online programme budget portal.	Gender is a key component of WHO's new General Programme of Work (GPW13), built on the "Three Billions" of beneficiaries that WHO is targeting for improved health outcomes (UHC, emergencies and healthier populations), embodying all gender angles including equal access to healthcare across genders and community contribution to programming.	Are you using the common reporting template as the standard for reporting by your downstream partners? if yes, on which level (global, limited scope (e.g. regional) If your scope is limited, please specify how and why?[7]	No
HUMANITARIAN-DEVELOPMENT NEXUS							
10.4. Perform joint multi-hazard risk and vulnerability analysis, and multi-year planning where feasible and relevant, with national, regional and local coordination in order to achieve a shared vision for outcomes. Such a shared vision for outcomes will be developed on the basis of shared risk analysis between humanitarian, development, stabilisation and peacebuilding communities.	Joint - all	Having worked across agency lines in 2020 to develop cross-sectoral guidelines for humanitarian response in COVID-19 settings, in 2021 WHO continued to work closely with other UN and IASC partners in areas such as community risk communication, surveillance and logistics.	In 2021, WHO's focus with respect to the Nexus has been: supporting/leading the UN system's efforts to combat the COVID-19 pandemic particularly in low-capacity and fragile and conflict-affected (FCV) countries, "stay and deliver" in continuing to support Ministries of Health, and to continue the organization's goal of achieving Universal Health Coverage (UHC).	Through the Global Health for Peace Initiative (GHPI)'s conceptual development in 2021, WHO worked closely with the UN's Peacebuilding Support Office and non-UN peace actors to articulate a more proactive role for health in building social cohesion in the African and Middle East regions.	Gender is a key component of WHO's new General Programme of Work (GPW13), built on the "Three Billions" of beneficiaries that WHO is targeting for improved health outcomes (UHC, emergencies and healthier populations), embodying all gender angles including equal access to healthcare across genders and community contribution to programming.	**N/A[8]**	**N/A**