

# **WHO reforms for a healthy future**

## **Report by the Director-General**

### **INTRODUCTION**

1. WHO has been at the forefront of improving health around the world since its founding in 1948. But the challenges confronting public health have changed in profound ways and with exceptional speed. While WHO continues to play a leading role in global health, it needs to evolve to keep pace with these changes. This is the overall purpose of reform.

2. The reform agenda began with a focus on financing and the need for better alignment between objectives and resources. A Member State-led process has since evolved to address more fundamental questions about WHO's priorities, its changing role in global health governance, and internal governance and managerial reforms needed for the Organization to be more effective and accountable. The continuing financial crisis means that the need for predictable and sustainable financing remains a central concern.

3. At the Sixty-fourth World Health Assembly,<sup>1</sup> and at the Executive Board's 129th session in May 2011, three objectives of reform were defined:

(1) Improved health outcomes, with WHO meeting the expectations of its Member States and partners in addressing agreed global health priorities, focused on the actions and areas where the Organization has a unique function or comparative advantage, and financed in a way that facilitates this focus.

(2) Greater coherence in global health, with WHO playing a leading role in enabling the many different actors to play an active and effective role in contributing to the health of all peoples.

(3) An Organization that pursues excellence; one that is effective, efficient, responsive, objective, transparent and accountable.

4. Since May 2011, three distinct and interconnected fields of work have emerged in line with these objectives: WHO's programmes and priorities; the governance of WHO and WHO's role in global health governance; and management reforms.

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<sup>1</sup> See document A64/4.

5. Consultations with Member States between the Board's decision to establish the process in May,<sup>1</sup> and leading up to the special session of the Board in November, focused initially on three specific issues: independent evaluation, the governance of WHO, and the World Health Forum. More recently, Member States have also received and commented on a separate paper on managerial reforms.

6. The present paper brings the three major lines of work – programmes and priorities, governance, and management reforms – together again. It incorporates feedback on the three concept papers presented to the Regional Committees, the draft managerial reforms paper, as well as other comments made by Member States through the web platform. In addition, it has benefited from the input of senior management and staff of the WHO Secretariat.

7. Programmatic, managerial and governance issues are closely interconnected. New health challenges and a more complex institutional landscape require different programmatic responses and place new demands on WHO's governance. Similarly, management reforms cannot be planned in isolation from the programmes and new ways of working that they are designed to support.

8. Although there is an overall consensus on the need for reform, the different elements of it are at different stages of development. They also require different types of decisions by the Board. In the area of management, the paper highlights where specific decisions are needed, and distinguishes those areas from the ones in which work is already being carried out under the authority of the Director-General. In the area of governance, the paper sets out several options and seeks the Board's guidance on which ones are the best candidates for more in-depth work.

9. This document is organized in three chapters:

(1) **Chapter 1:** sets out the **programmatic work** of WHO and proposed approaches to **priority setting**. It demonstrates how action in five core areas – health development, health systems, health security, health trends and determinants, and convening for health – can address current and emerging health challenges. Chapter 1 also outlines how work to date on programmes and priorities will form the basis of the next general programme of work. The Board is asked to reaffirm support for the five core areas and to provide guidance on the development of the next general programme of work.

(2) **Chapter 2** addresses **governance** from two perspectives: the governance by Member States of the Organization itself, and the role that WHO plays in global health governance. The first part is organized around the formal governance structures of WHO and sets out, for each structure, challenges and a range of mutually supportive options by which those structures can be strengthened. The second part discusses WHO's leadership role in global health, both in terms of engagement with other stakeholders and how WHO can promote greater coherence and coordination among the many actors involved in global health at global and country level. As in the first part of this chapter, the second part also sets out a series of options on which the Board is asked to provide guidance.

(3) **Chapter 3** deals in more detail with **management reforms** in five areas: organizational effectiveness, financing and resource mobilization; human resources policy and management;

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<sup>1</sup> Decision EB129(8).

results-based planning, management and accountability; and strategic communications. Each section sets out issues to be addressed and how proposed changes will improve performance by better alignment of work in the three levels of the Organization in order to respond to new ways of working, particularly for more efficient delivery at country level. Ongoing work by the Secretariat is distinguished from new proposals that require a decision by the Board. For the most significant reforms, next steps are identified, providing, where appropriate, more detail on timelines, resource implications and approaches to implementation.

## CHAPTER 1: PROGRAMMES AND PRIORITY SETTING

### PROGRAMMES

#### Challenges and opportunities

10. Over the next decade new challenges and opportunities in global health will continue to shape the work of WHO. As gaps in income levels within and between countries continue to widen, the focus on growing inequities and their consequences for health becomes sharper. At the same time, the distinction between developed, developing and emerging economies becomes blurred in a world better understood in terms of overlapping networks and alliances of countries with common interests.

11. Countries will face common challenges in addressing the health of their populations, many of which go beyond the health sector: rapid, unplanned urbanization, ageing populations, competition for scarce natural resources, economic uncertainty, migration, and the impact of climate on the fundamental requirements for health – clean air, safe and sufficient drinking-water, a secure food supply and adequate nutrition and shelter. Effective responses require collaborative solutions, not just between sectors but also across countries, across regions and at the global level.

12. Epidemiological and demographic transitions impose an increasingly complex burden: infectious diseases in tandem with noncommunicable diseases, mental health, injuries and the consequences of violence. Thus, while progress on all health-related Millennium Development Goals, between and within countries, is uneven and much unfinished business remains, particularly in relation to eradication and elimination of diseases, and the health of women and children, countries have to face the growing challenges of chronic disease.

13. In many countries, the net effect of the increasing costs of technology, ageing populations and rising public expectations is to threaten the financial sustainability of health systems. In contrast, the future in other countries will be one in which current challenges continue, with inadequate levels of unpredictable funding, limited access to life-saving technologies, lack of financial coverage and a continuing daily toll of unnecessary death and disability from preventable causes.

14. Good use of information and communications technology can make health professionals more effective, health-care facilities more efficient and people more aware of the risks and resources that can influence their health. The challenge is to harness innovation, in both the public and private sector. But doing so equitably involves using incentives and the stewardship of resources in ways that ensure that technology development is an ethical servant to the health of the world's poor.

15. Shocks must also be anticipated, including those delivered by new and re-emerging diseases and from conflicts and natural disasters. Such shocks are certain to continue, even though their provenance, location, severity and magnitude cannot be predicted. Conflict and the population displacement that follows especially affect the health of women and children.

16. Finally, the first decade of the 21st century has seen growing complexity in the institutional landscape for global health, characterized by more partnerships, foundations, financial instruments, and bilateral and multilateral agencies that influence global health policy-making. The challenge is to manage complexity and seek creative solutions that promote convergence around common goals.

17. There are also opportunities to improve collaboration and use innovation, at national and international levels, to fight inequities and to continue progress for better health. These include: greater political awareness and commitment to prevent and control noncommunicable diseases in all countries; innovations that produce medicines and vaccines for diseases that affect the developing world; the public health potential of information and communication technologies; and the increasing contribution of emerging economies to capacity building, including through technology transfer in south-south or north-south collaboration, and to the production of low-priced, high-quality generic medicines and vaccines.

**18. Against this backdrop of challenges and opportunities, WHO envisages a world where gaps in health outcomes are narrowed; access to universal health care has expanded; and countries have resilient health systems, based on primary health care, which are able to meet the expectations and needs of their people, reach internationally agreed health goals, control noncommunicable diseases and cope with disease outbreaks and natural disasters.**

### **The work of WHO**

19. The mission of WHO, as an organization of Member States, is based on the constitutional objective of “the attainment by all peoples of the highest possible level of health”, with universality, equity, and health as a human right at the centre of this mission. This broad mission distinguishes WHO from organizations with a more narrow focus.

20. The values of WHO continue to be grounded in a fundamental concern for equity and human rights; gender equality and the greater empowerment of women; and based on the principles of collective responsibility, shared vulnerabilities, sustained solidarity, and health as a global public good.

21. WHO’s work affects peoples’ lives: through the development of international health policy instruments such as the Framework Convention on Tobacco Control and the International Health Regulations (2005); by enhancing access to essential medicines, vaccines and diagnostics by setting standards, developing treatment guidelines, increasing supply and lowering costs through prequalification of manufacturers and procurement agencies; and by providing the hands-on support and advice needed at country level to build strong health systems and to make more rapid progress towards universal access to health care. When emergencies strike, outbreaks threaten or national systems fail WHO can also act directly to help protect lives and livelihoods.

22. Measuring impact in terms of lives saved, risks to health averted and populations covered by essential services is key to sustaining support for WHO. In addition, if results are achieved through the work of others, then measures of collective achievement are needed. WHO will therefore articulate a set of high-level, measurable targets in global health, which will result from the work of the Secretariat and Member States and other partners. Achievement against these targets will complement more direct measures of Secretariat performance and act as a tool for holding WHO accountable as well as offering a means of measuring collective impact and value for money. These targets will be developed – in collaboration with Member States – as part of the development of the next general programme of work.

23. There is a consensus among Member States that WHO should focus on what it does best. It is also important that there is a clear link between the core areas of the Organization’s work and the public health challenges facing countries.

24. The five core areas of work – health development, health security, strengthening health systems and institutions, evidence on health trends and determinants, and convening for better health – distinguish WHO from organizations whose prime function is to manage and disburse loans and grants as their main lines of business, and from institutions that develop knowledge without necessarily being responsible for its application.

***Health development: determinants, risks, diseases and conditions***

25. The work of WHO not only addresses diseases and their treatment, but also encompasses strategies for addressing root causes of ill health, including health risks and determinants. Health is both a beneficiary of and a contributor to sustainable development. Future work in WHO will increasingly be concerned with building the capacity needed in countries to monitor and act on the environmental, economic and social determinants of health.

26. Communicable diseases, such as HIV/AIDS, tuberculosis and malaria; sexual and reproductive health; and women's, children's and adolescent health, will remain priorities for the Organization. The elimination or eradication of individual infectious diseases: poliomyelitis, measles, dracunculiasis, and several other neglected tropical diseases also remains a high priority.

27. The focus on noncommunicable diseases will act as a driver and an integrating force for the work of WHO. Rather than tackling noncommunicable diseases as the specialist interest of one part of the Organization, the approach will address noncommunicable diseases through the work of all parts of the Organization. It will be tackled through health systems, access to medicines, and research and innovation, similarly to the way in which communicable diseases and women's and children's health have been tackled. The rise of noncommunicable diseases poses a clear threat to sustainable development. The priority now is to move from advocacy to action aimed at controlling these diseases at both population and individual levels. The work on noncommunicable diseases also provides an opportunity for WHO to exercise leadership in working with other sectors and partners to implement the political declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (September 2011).<sup>1</sup>

28. A two-pronged approach to noncommunicable diseases is critical. At the **population level**, policy changes in multiple sectors, as advocated by the Commission on Social Determinants of Health, are needed to make healthy choices the easy choices. At the **individual level**, prevention and control require promotion of healthy lifestyles, early detection, improved access to more affordable pharmaceutical products, new products suitable for use in resource-constrained settings, and simplified treatment regimens that can be delivered through primary health care.

***Health security: public health and humanitarian emergencies***

29. Protecting lives when emergency or disaster strikes is a vital part of WHO's work. Challenges can be acute in the case of outbreaks, pandemics or natural disasters. But they can also be more long-term, as in the protracted and uncertain process of recovery that follows civil conflict, or the gradual but potentially devastating effects of climate change.

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<sup>1</sup> See United Nations General Assembly document A/66/L.1.

30. WHO has several roles: as convenor at global level to reach global consensus (such as the International Health Regulations (2005) and the Pandemic Influenza Preparedness Framework) and in humanitarian emergencies as coordinator of the health cluster. Increasingly, the focus at country level will be to develop local capacity, to strengthen systems for surveillance and response, to ensure greater preparedness and to build more resilient health care institutions.

31. The world's principal defence against surprises arising from the microbial world continues to come from WHO systems and programmes that gather real-time intelligence about emerging and epidemic-prone diseases, verify rumours, issue early alerts, and mount an immediate international response aimed at containing the threat at its source.

### ***Strengthening health systems and institutions***

32. The strengthening of national health systems and public health functions, based on the principles of primary health care and universal coverage, underpins many aspects of the Organization's work – not just in terms of technical content but by providing a set of guiding values. Reforms in universal coverage, service delivery and public policy reflect a convergence between the values of primary health care, the expectations of citizens and the common health performance challenges that cut across all contexts.

33. In the last few years, the Organization's work has focused on the building blocks of health systems (health service delivery, health workforce, health information systems, access to essential medicines, health systems financing, and leadership and governance). Now WHO's focus will be to put those building blocks together into an integrated framework at community, district and national levels. Work on health systems is relevant to all countries, but the approach adopted will vary from country to country and from region to region. The majority of technical support will be directed to countries with the weakest systems. In other parts of the world, the focus will be on policy analysis and dialogue and facilitating exchange between countries facing similar issues.

34. Another challenge is the growing number of organizations active in supporting health. To address this concern, work at country level will shift increasingly to working with national authorities to develop policies, strategies and plans around which other development partners can align.

35. Access to essential, high-quality, and affordable medical products is one aspect of equity in public health. Affordable prices ease health budgets everywhere but are especially important in developing countries, where the majority of people pay for health-care services out-of-pocket. Access to high-quality affordable medical products becomes all the more critical in view of the shifting of the burden of noncommunicable diseases, requiring chronic if not life-long medical treatment, to the developing world.

36. A related priority is the strengthening of national regulatory capacities. Norms and standards set by WHO to safeguard public health have little impact if countries lack the capacity to regulate and enforce compliance with these standards.

### ***Evidence on health trends and determinants***

37. The collection, collation, analysis and dissemination of health data from all countries in the world, and the strengthening of the health information systems that yield and use these data, are central to WHO's work. Monitoring allows the world to keep track of progress against internationally agreed goals, such as the Millennium Development Goals. It also identifies the obstacles to be

overcome in accelerating progress; allows stakeholders to be held accountable for resources committed and results achieved; shows trends in relation to gender, equity and progressive realization of human rights; and informs investment decisions.

38. The analysis of trends and determinants helps shape the health research agenda and build evidence, and is a key element in promoting health in all policies, and in identifying neglected health problems. WHO will use its analytical work to anticipate trends that may influence health.

### ***Convening for better health***

39. WHO's role as a convenor is central to the Organization's stewardship and leadership role in global health governance (see chapter 2); for developing negotiated instruments that address universally shared problems; and, at a technical level, it provides the means for preparing independent and evidence-based guidelines.

40. Health is also increasingly affected by decisions made in other forums. WHO will seek to use its influence where international rules and agreements are developed and monitored by other institutions (e.g. animal health, food security, agriculture, the environment and trade). In all these areas, the priority will be to clearly delineate the ethical and evidence base for WHO's position, and to ensure a focus on better health as a key outcome.

41. Few challenges to public health affect only single countries. Rather, their impact is felt across groups of countries. It is in this light that WHO's capacity to convene at regional level is becoming increasingly important, along with the need to work closely with other regional and subregional bodies such as development banks and political and economic integration organizations. At country level, as noted above, convening partners is central to increasing organizational effectiveness.

## **PRIORITY SETTING**

42. The five areas constitute a framework within which priority setting will take place. This is an area that many Member States have recognized is fundamental to WHO reform, as a clear set of priorities will guide results and resource allocation. However, this work is complex and takes place at different levels. Given that Member States will have a critical role in the process, there is a need for a framework and agreed criteria to guide the process. Further, it is clear that priority setting is best done in conjunction with the preparation of the general programme of work and the programme budget.

### **Possible approach**

43. Priority setting could be approached at two levels: flagship (or Organization-wide) priorities; and priorities within the five core areas of work.

44. Top-level *flagship priorities* reflect global concerns. They will be the focus of Organization-wide effort and will be linked to impact targets to be achieved by Member States, with support from the Secretariat and partners. In the next 10 years, flagship priorities are likely to include communicable diseases and noncommunicable diseases, strengthening health systems, increasing equitable access to medicines and vaccines, and support to countries for the achievement of the health-related Millennium Development Goals. This level of priority setting will be clarified in the next general programme of work.



45. The next level of priority setting focuses on work *within the five core areas* delineated above. The five areas are not priorities per se as they exclude very little, but can be used as a framework for determining what WHO should and should not do. As an organization of Member States, WHO has to respond to any issue that affects its membership. This responsibility does not mean, however, that WHO has to do everything itself or cover everything in the same way. This level of priority setting will be clarified in the next programme budget.

46. To facilitate priority setting by Member States, the next step is to agree on criteria. These will include: burden of disease, need and demand of Member States, and current capacity and mandate at different levels of the Organization. These criteria may not be equally relevant to all five areas of work, and thus will have different weighting in their application. Consideration must be given to priority setting among the six core functions and between the five areas of work.

47. This work is at an early stage of development. Guidance from Member States is needed to: identify a limited number flagship priorities and link these with high-level impact targets; define criteria for priority setting within the five core areas of work; and consider ways in which priorities will be applied in planning for results and resource allocation. Based on this guidance, the Secretariat will develop a detailed proposal for priority setting to be submitted to the Board in January 2012 through the Programme, Budget and Administration Committee.

**Recommendation**

*The Board is invited to: endorse the direction for WHO's work and to request the Secretariat to develop further proposals for priority setting, to be submitted to the Board in January 2012, through the Programme, Budget and Administration Committee.*

## **CHAPTER 2: GOVERNANCE**

48. WHO's governance has served it well. However, the evolution of WHO's work and the increasing number of players in global health necessitate changes in the way WHO is governed, so that it can continue to carry out its mandate as the directing and coordinating authority on international health work. The proposed reforms in governance cover two areas: the internal governance of WHO by Member States and the role of WHO in global health governance. The fundamental objectives for the internal governance reforms are to foster a more strategic and disciplined approach to priority setting, to enhance the oversight of the programmatic and financial aspects of the Organization, and to improve the efficiency and inclusivity of intergovernmental consensus building, by strengthening the methods of work of the governing bodies. The main objective of reforming WHO's role in global health governance is to increase the level of engagement with other stakeholders who influence global health policy and to capitalize more effectively on WHO's leadership position to bring about greater coherence among the many actors involved in global health.

### **WHO governance**

#### **Summary of proposals**

49. The proposals for change focus on improving the work of the governing bodies: the World Health Assembly, the Executive Board and the Regional Committees. For the Board, proposals include strengthening its executive and oversight roles; increasing its strategic role; and improving its methods of work. For the Health Assembly, proposals include increasing strategic focus and decreasing the number of resolutions to enable better priority setting; and improving the methods of work of its committees and working groups. For the Regional Committees, proposals include strengthening global–regional linkages, connecting their work more closely with that of the Board, and standardizing practices across different regions. In addition, proposals are made for how the Secretariat can improve the support it provides to governance functions.

#### **Executive Board**

##### ***Background***

50. The Board has two roles: an executive role, ensuring that the decisions and instructions of the Health Assembly are carried out, and providing guidance and direction to the Secretariat; and an advisory role, supporting the preparation of the work of the Health Assembly's sessions. The Board submits a general programme of work to the Health Assembly for its consideration. The Board also has the power to take emergency measures.

51. The Board normally meets in January and May. In January it prepares the provisional agenda for the Health Assembly and recommends draft resolutions for adoption. The Board can also adopt formal decisions. The January session lasts an average of six working days in non-budget years and eight working days in budget years. The May session of the Board immediately follows the Health Assembly, and usually lasts for one day or less.

52. In May the Board elects Officers of the Board for a one-year term: a Chairman, four Vice-Chairmen and a Rapporteur (known also as the "Bureau"). The May Board discusses the outcome of the Health Assembly and mainly deals with administrative matters. One of the Officers' main

functions is to hold an intersessional consultation with the Director-General on the draft provisional agenda, which includes proposals received from Member States for additional items. The Officers may recommend the deferral or exclusion of proposals on the basis of established screening criteria.

53. There are 34 Member States entitled to designate a person to serve on the Board. Members of the Board have full voting rights. Other Member States may designate a representative to attend and participate in Board meetings, but without voting rights. Representatives of United Nations entities, other intergovernmental organizations and nongovernmental organizations in official relations with WHO also participate.

54. The Board has two subsidiary bodies: the Programme, Budget and Administration Committee (PBAC) and the Standing Committee on Nongovernmental Organizations. The Programme, Budget and Administration Committee was established in 2005 through a merger of existing committees. It meets before the Board's session in January and immediately before the Health Assembly in May. It makes recommendations to the Board on the general programme of work, programme budgets, performance and assessment reports, financial reports, audit plans, and the Secretariat's responses.

55. The Programme, Budget and Administration Committee is advised by the Independent Expert Oversight Advisory Committee, a body whose main purpose is to support the PBAC and, through it, the Board, in fulfilling their oversight advisory responsibilities. In addition, upon request, the Independent Expert Oversight Advisory Committee may advise the Director-General on issues within its mandate.

56. The Standing Committee on Nongovernmental Organizations (composed of five Board members) usually meets during the January session of the Board. It considers whether applications from nongovernmental organizations for admission into official relations with WHO meet the required criteria. The Standing Committee also reviews the status of collaboration with one third of its membership each year (currently 186 in total) and makes recommendations on discontinuation of relations.

57. The demands involved in preparing the agenda and work of the Health Assembly currently prevent the Board from exercising fully its executive and oversight role. In the last 10 years the number of agenda items of the Board has ranged from 31 to 55 for its January sessions, and from 3 to 19 for its May sessions.

58. The lack of agreed medium-term priorities affects the Board's ability to function effectively as a gatekeeper to limit the number of agenda items and thus maintain the Health Assembly's strategic focus.

59. The Board faces challenges in reconciling the openness and inclusiveness of its methods of work with its need to perform executive and oversight functions.

60. The governing bodies do not effectively oversee the managerial and fiscal soundness of the Secretariat's work and are not adequately involved in evaluating the work of WHO.

### ***Proposals***

61. To **strengthen the Board's strategic role** and to provide a more robust basis for priority setting it is proposed that a four or five-year plan of work be developed to guide the governing bodies' work-. The governance plan would outline priorities to be addressed, and set out provisional timelines. The

first draft of such a plan would be prepared by the Programme, Budget and Administration Committee and then be further developed by the Board before being adopted by the Health Assembly.

62. The Board would:

- (1) ensure that only proposed items and draft resolutions that fall within the agreed strategic workplan are placed on the Health Assembly agenda and define the criteria under which the workplan can be adjusted;
- (2) develop clear and enforceable criteria that limit the number of resolutions submitted directly to the Health Assembly;
- (3) examine all progress reports and only exceptionally refer them to the Health Assembly;
- (4) play a central role, through the work of the Officers of the Board, in managing the Board's discussions and its consideration of draft resolutions as well as in the preparation of the Health Assembly's provisional agenda.

63. To **strengthen its own executive and oversight role** the Board may wish to consider proposals to:

- (1) hold an additional session in the third quarter of the year (this has financial implications – the cost of a Board session currently averages US\$ \$1.2 million – however some of this additional expense may be offset by reducing the number or duration of intergovernmental working groups);
- (2) request the Officers of the Board to play a stronger intersessional role beyond their discussion of the provisional agenda, e.g. by coordinating informal consultations or hearings with different stakeholders;
- (3) expand the role of the Board in programme monitoring and evaluation and in guiding the Organization's work with partnerships.

Options include:

- (i) expand the work of the Programme, Budget and Administration Committee so that it has a more substantive role in programmatic issues. For example, the Board might request it to undertake the initial development of the plan of work for the governing bodies for consideration by the Board and the Health Assembly;
- (ii) establish a new monitoring and evaluation committee to oversee programmatic and financial implementation at the three levels of the Organization and thereby create a mechanism for independent evaluation of the work of WHO;
- (iii) establish a committee that guides WHO involvement in partnerships. Alternatively, expand the current Standing Committee on Nongovernmental Organizations to include partnerships.

64. To improve **its methods of work** the Board may wish to consider proposals to:

- (1) hold meetings of its subsidiary bodies in November as part of the proposed new third session, to allow for further work on the items and ensure thoroughly revised submissions for consideration in January;
- (2) use modern communications technologies for virtual meetings on urgent issues;
- (3) enforce speaking time limits using a “traffic light” system.

### **Recommendations**

*The Board is invited (1) to endorse the proposal for a medium-term plan of work for the governing bodies and provide guidance on its development, and (2) to identify items from the list of proposals for further development by the Secretariat.*

## **World Health Assembly**

### ***Background***

65. The World Health Assembly, the supreme decision-making body of WHO, meets yearly in May in Geneva, on average for eight working days in a year in which the proposed programme budget is discussed, and six working days in a non-budget year. It determines the policies of the Organization; adopts international conventions, regulations and recommendations; appoints the Director-General; supervises the financial policies of the Organization; and reviews and approves the proposed programme budget and assessed contributions.

66. The Health Assembly has two main committees: Committee A principally deals with programme and budget matters; Committee B principally deals with administrative, financial and legal matters. The Health Assembly may also choose to establish other committees.

67. The Health Assembly agenda is shaped by a mix of recommendations by the Board; items proposed by Member States; reporting requirements contained in the resolutions adopted; statutory issues; and items suggested by the Secretariat. There is no formal mechanism for aligning the Health Assembly agenda with global health priorities.

68. Member States have commented that the Health Assembly agenda contains too many items, especially in light of their stated preference for short sessions. In the last 12 years the number of agenda items has risen from 39 to 67 each year. A large number of resolutions are adopted, some in areas that are not high priorities for global health. The process of preparing those resolutions in-session can be time-consuming for Member States, for example when drafting groups are needed; in addition, once resolutions are adopted, they bring long term substantial reporting and other requirements.

69. Health Assembly Officers include the President and five Vice-Presidents, elected on the first day of the meeting. The Chairmen of Committees A and B and seventeen other delegates elected by the Health Assembly form the General Committee. The General Committee determines the Health Assembly’s timetable of work, considers the provisional agenda, makes proposals on the allocation of

items to the committees and possible deferments, coordinates the work of all committees, and generally facilitates the Health Assembly's work.

70. All Member States participate in the Health Assembly, along with United Nations organizations and other intergovernmental organizations, and nongovernmental organizations in official relations with WHO.

71. Over the past few years there has been a growing trend to establish intergovernmental processes and negotiations stemming from the deliberations of the Health Assembly. Several of these have contributed to building consensus in global health and the adoption of several key international health policy instruments. These open-ended intergovernmental working groups increase the workload for both Member States and the Secretariat and have major cost implications. The average cost is US\$ 750 000 for each five-day meeting. Consideration should be given to rationalizing these exercises and reducing costs by focusing them on major public health priority issues that need detailed intergovernmental negotiations and entrusting some of these negotiations to the Board.

### ***Proposals***

72. To improve the Health Assembly's strategic focus and priority setting, the Board may wish to consider the proposals for it to:

- (1) prepare a multi-year programme of work to guide the governing bodies, for the Health Assembly to adopt;
- (2) use clear and enforceable criteria to filter out agenda items that go beyond the agreed priorities.

73. To decrease the number of resolutions, while strengthening their content and implementation, the Board could consider the following options:

- (1) request that the General Committee adopt the same role as the Officers of the Board and play a steering role to ensure discipline and prioritization, including assessing the value and cost of new resolutions. Alternatively, establish a new resolutions committee to play this role;
- (2) develop and use a standard framework for resolutions, which will include implications for budgets, monitoring and reporting;
- (3) replace formal resolutions, when appropriate, with a summary of discussions proposed by the Chairman or by "agreed conclusions" (a system used in other United Nations organizations);
- (4) prepare fewer but broader ("omnibus") resolutions to be submitted to the Health Assembly by the Board;
- (5) adhere to a deadline for proposing draft resolutions during sessions;
- (6) include a default clause that would limit reporting on any resolution to a maximum of six instances.

74. Rationalize the mechanism of intergovernmental working groups by entrusting certain negotiations to the Board instead.

75. To improve the methods of work of committees and groups:
- (1) debates should become more disciplined to discourage lengthy national reports and focus on the substance of the item;
  - (2) Institute as the norm a “traffic light” system and enforcement by chairmen of time-limits.

### **Recommendations**

*The Board is invited to review the proposals above, modify them as appropriate and endorse them.*

## **Regional Committees**

### ***Background***

76. Regional Committees meet once a year, between the end of August and mid-October. Their main functions are to formulate regional policies and programmes; to provide comments and guidance on the work of WHO that would promote the objectives of the Organization in the region; to supervise the activities of the Regional Offices; and to discuss matters assigned by the Health Assembly or the Board.
77. Regional Committees have different arrangements with respect to their subsidiary bodies and for dealing with specific agenda items and preparing their sessions. Regional Committees’ practices and methods of work also vary considerably; greater standardization could be attained.
78. Linkages between global and regional levels of governance are weak, and strategic alignment between regional and global governing bodies is needed. Outcomes of the Health Assembly and the Board are incorporated into Regional Committee discussions, however Regional Committee discussions are not adequately reflected in the agenda and discussions of the Board.

### ***Proposals***

79. To improve global-regional linkages the Board may wish to consider the following:
- (1) Regional Committees should automatically include agreed priority items from the Board in the agendas of the Regional Committees, as part of the multi-year programme of work of the governing bodies;
  - (2) Officers of the Board should refer some items to Regional Committees for discussion rather than to the Board.
80. To link Regional Committees with the Board:
- (1) Regional Committees should report regularly to the Board and contribute to Board and Health Assembly deliberations;

(2) Regional Committees should directly propose agenda items and draft resolutions to the Board;

(3) Officers of the Board should consult with the Bureaux of the Regional Committees on the Board's draft provisional agenda.

81. To harmonize their practices, Regional Committees should:

(1) adopt uniform procedures to consider the credentials of Member States through credentials committees;

(2) adopt uniform processes for Regional Director nominations (criteria, interviews);

(3) agree on a unified approach in relation to attendance by observers;

(4) standardize intersessional work.

### **Recommendations**

*The Board is invited to review the proposals above, modify them as appropriate and endorse them.*

## **Improving support by the Secretariat**

### **Background**

82. Not all Member States have the time and resources to adequately prepare for and participate in governing body meetings.

83. Documentation by the Secretariat is not always available on time.

### **Proposals**

84. The Board may wish to instruct the Secretariat to:

(1) enhance support to Member States' participation in governing body meetings, with greater exchange of information through electronic and other means;

(2) give more briefings for Member States on the background of issues to be discussed;

(3) give detailed briefings to Member States newly elected to the Board;

(4) where appropriate, create new and more systematic ways to involve regional economic integration organizations;

(5) ensure that the Secretariat has the right skill mix and political awareness to effectively support the governing bodies;



- (6) review the schedule for distribution of documents to ensure that Member States receive information in a timely manner.

### **Recommendations**

*The Board is invited to review the proposals above, modify them as appropriate and endorse them.*

## **WHO's role in global health governance**

### **Background**

85. A growing number of institutions, in addition to governments, including foundations, partnerships, civil society organizations and the private sector, have a role in influencing policy and priority setting for health. The challenge of broadening engagement beyond governments to include other stakeholders, while at the same time promoting greater policy and financial coherence, is generally referred to as *global health governance*.

### **Summary of proposals**

86. Proposals address two elements of governance: engagement and coherence. They include three principal formats for engaging with other stakeholders. The issue of coherence is addressed in four different contexts: as part of the United Nations development work at global and country level; through a range of coalitions and alliances that extend beyond the United Nations to address a range of different health issues; through partnerships; and through some form of framework or code of conduct.

### **Principles**

87. Feedback clearly shows the key challenge being to determine how WHO can engage with a wider range of players without undermining its intergovernmental nature or opening itself to influence by those with vested interests. For this reason it is proposed that any option for reform be considered in the light of the following principles:

- (1) retention of the intergovernmental nature of WHO's decision-making remains paramount;
- (2) the development of norms, standards, policies and strategies, which lies at the heart of WHO's work, must continue to be based on the systematic use of evidence and protected from influence by any form of vested interest;
- (3) neither increasing engagement nor promoting coherence are ends in themselves: any new initiative must have clear benefits and add value in terms of enriching policy or increasing national capacity;
- (4) building on existing mechanisms should take precedence over creating new forums, meetings or structures, with a clear analysis provided of how any additional costs can lead to better outcomes.

## *Proposals*

### **Widening engagement**

88. A previous concept paper discussed the idea of a World Health Forum, but feedback from Member States was not supportive. Therefore, three formats for widening engagement are proposed here. They are also not mutually exclusive.

89. The first proposed format is to hold **multi-stakeholder forums** on key issues in global health. Stakeholders interact with each other and with governments. A recent example, which brought together civil society, governments and the private sector, is the WHO Global Forum: Addressing the challenges of noncommunicable diseases, held in April 2011 before the Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control in Moscow.

90. An alternative is to conduct separate **consultations with different groups of stakeholders** to provide input on specific issues under consideration by Member States. In this format the parties do not interact with each other; rather, each meeting would take place between a stakeholder group and WHO. The exchange of views is bilateral, and the format resembles a parliamentary hearing more than a conference. The Co-Chairs conducted consultations in this manner during the Open-ended Working Group of Member States on Pandemic Influenza Preparedness: sharing of influenza viruses and access to vaccines and other benefits.

91. In a consultation stakeholders are free to comment on any aspect of the issue at hand. A final option is to restrict the role of stakeholders to commenting on specific aspects of an issue in which the group has particular expertise or experience. Consultations can take place through **face-to-face meetings or web-based forums**. Such web-based consultations can be made open to all. Similar formats can be considered at regional level.

### **Strengthening coordination: within the United Nations**

92. The first priority for engagement with the United Nations will be to ensure that health is actively supported and well represented in intergovernmental processes (for example in the United Nations General Assembly and other such councils and commissions).

93. Second, at a global level, WHO will focus on United Nations coordination at the highest level, through the Chief Executives Board for Coordination, the High-level Committee on Programmes (HLCP) and the High-Level Committee on Management (HLCM). It will caution against any further duplication of processes.

94. Third, to increase support to United Nations country teams, WHO will become increasingly active as a Member of the United Nations Regional Directors' Teams and Peer Support Groups.

### **Strengthening coordination: coalitions and alliances**

95. Achieving better outcomes requires a more coherent approach not just within the United Nations, but across a range of other partners (funds, bilaterals, development banks, foundations, civil society organizations, nongovernmental organizations and private entities). This approach will build on existing mechanisms as well as less formal alliances (rather than creating new, formally structured partnerships). Proposals include: strengthening WHO's work and the place of health through more effective leadership of the Inter-Agency Standing Committee health cluster; pursuing better outcomes

in areas such as maternal health (through H4+) and through new alliances that will focus on the prevention and control of noncommunicable diseases; and increasing WHO's influence on aid effectiveness, at country level through Health and Harmonization in Africa and the International Health Partnership, and at global level, ensuring that health has a prominent place in the follow up to the Fourth High-level Forum on Aid Effectiveness.

### **Work in partnerships**

96. A key part of the development architecture has been the creation of a wide range of formally structured partnerships. Some are independent entities, but include WHO as part of their governance bodies. Leveraging that presence and increasing WHO's effectiveness in those entities as a Board member is a key part of the reform agenda. Other partnerships are hosted by WHO, but have separate governance mechanisms, raising a complex series of issues around accountability. Many Member States are members of partnership boards as well as being part of WHO's governance. Ensuring consistency in their interactions across these different forums remains a challenge. Given the importance and range of issues involved, the WHO Board could play an important role in bringing greater coherence to the world of partnerships, for example, through expansion of the role of the Standing Committee on Nongovernmental Organizations to include partnerships.

### **Develop a framework to guide stakeholder interaction**

97. In the longer term, an option could be the development of a framework that can guide the interactions between all stakeholders active in health. This would be a legitimate expression of WHO's role as a directing and coordinating authority. Member States will need to consider options for the form of such a framework and the process through which it is developed. Such a framework can be based either on agreed targets and indicators (making the Paris Declaration on Aid Effectiveness more relevant for health), or it could be modelled on a code or charter, which sets out rights and responsibilities.

### **Recommendations**

*The Board is invited to endorse the principles set out above and provide guidance on the options for taking forward work on engagement and coherence.*

## CHAPTER 3: MANAGERIAL REFORMS

98. The proposed managerial reforms fall into five main areas: organizational effectiveness, alignment and efficiency; financing of the Organization; human resources policies and management; results-based planning, management and accountability; and a strategic communications framework.

### **Organizational effectiveness, alignment and efficiency**

#### *Summary of proposals*

99. Proposals in this section seek to increase effectiveness through better organization and ways of working. Four specific areas for improvement are addressed: strengthened support to countries and the work of country offices; alignment of headquarters and regional offices; better definition of roles, responsibilities and relationships between each level of the Organization; strategic relocation of some programmes and operations; and improvement of knowledge management.

#### *Background*

100. The purpose of this element of reform is to ensure that the work of the Secretariat is organized in ways that meet the changing health needs of Member States. This will include making the most effective use of a decentralized structure: defining the roles of different levels in ways that reduce duplication and overlap; and defining relationships between them in ways that promote synergy and collaboration. A second major challenge is to overcome the tendency for programmes and offices to work independently of one another. An integrated approach to health policy and strategy (and country support) requires strong horizontal linkages across all parts of WHO. This in turn means developing management systems that facilitate access to knowledge and expertise *across* technical and organizational boundaries.

101. WHO's primary role is support the efforts of national authorities. While the Secretariat provides technical support to *all* countries, it has a physical presence only in some. Two changes are required in this regard. First, there is a need for a better and more flexible match between the level of country support provided and the needs of the country concerned. Second, there is a need to emphasize that, in countries where the Secretariat has a physical presence, the support offered is not limited to the resources of the country office. The resources of the whole Organization are available. This includes the need for better alignment of headquarters, regional offices and country offices in the provision of country support and the strategic location of knowledge hubs and centres of expertise.

102. Perceptions differ among Member States, development agencies and donors, the United Nations system, non-state actors, global health initiatives, and humanitarian actors about WHO's role at country level. Overall, the Organization will be increasingly concerned with providing policy advice and helping national authorities to coordinate support from partners. But there are many countries where more direct engagement is required, for example when dealing with emergencies and outbreaks. In all circumstances, clear communication about what WHO does and does not do in each country is key to managing expectations. In addition, where it is needed, WHO must have the capacity to act quickly and reliably in response to critical events and to requests for technical cooperation.

103. Country teams are the most visible part of WHO's work in countries. The performance of country offices reflects the leadership of the head of the country office, the competencies and skill mix of the team, as well as the support they receive from the rest of the Secretariat. WHO country offices

need to be further strengthened through the right mix of staff skills and competencies, greater resources and enhanced delegation of authority along with consequently greater accountability.

104. As a knowledge-based Organization, WHO's ability to deliver results is dependent upon staff having rapid and easy access to information, evidence and experts. While considerable effort has been invested in improving access to administrative information, country-specific knowledge tends to be inadequately shared – contributing to the compartmentalization of WHO's work. In an era of ever-more powerful means of communication, through electronic and other mass media, this is an urgent problem to address.

### ***Proposals***

105. The fundamental idea underpinning the proposals to increase organizational effectiveness is to change the way the Secretariat works. The aim is to move from an Organization that delivers separate outputs through a series of technical programmes, to an Organization that achieves impact, working with national authorities, through the combined efforts of country offices, regional offices, headquarters and its various outposts, all operating as part of an inter-dependent network.

106. Inherent in what will be a gradual change is the need first to articulate roles and relationships more clearly, to define outputs for each part and level of the Organization, and thereby to link responsibility with greater accountability for results and the use of resources. This part of the paper focuses primarily on country support and the roles of headquarters and regional offices. The paper returns to the issue of accountability in the section on results-based management.

### **Strengthen country offices**

107. Country offices will be given greater authority to carry out their main functions. These are to: strengthen national capacities; act as provider/broker of policy advice and technical expertise; catalyse and convene partners; facilitate the country's contribution to regional and global health; and lead the international response to public health emergencies.

108. Greater delegated authority will be matched with correspondingly increased accountability. This in turn will require heads of country offices to have the requisite leadership and managerial skills as well as a level of seniority commensurate with their peers in other agencies.

109. Country work plans will more closely reflect the agreed strategic priorities, within the core areas of work, as defined in their country cooperation strategy. These work plans should be aligned to country priorities, according to the needs and capacities of the country, and must take into account the capacity of the United Nations and other health and development partners. The country cooperation strategy will increasingly define a *small* number of priority areas of action where WHO support will be concentrated, rather than seek to find a place for every area of WHO's work.

110. Human and financial resources will be adjusted – drawing where necessary on headquarters and regional office resources – in line with country cooperation strategy priorities. As WHO increasingly takes on the role of strategic adviser and convenor, staff with the necessary skills and experience will join country offices. WHO will remain a consistent supporter of the United Nations country team, leading where appropriate on issues concerned with health.

111. To ensure a better match between national needs and WHO support, a typology or set of scenarios will be developed that can be used to determine the need for, and the size of, Secretariat

presence. In many countries, there may be no need for a permanent WHO presence of dedicated focal points for each of the core areas of work, but they will need technical support through surge mechanisms from regional or headquarters' levels for as long as necessary. Some countries will require a permanent presence of technical expertise.

### **Promoting alignment, synergy and collaboration**

112. Reform will ensure that headquarters, regional and country offices work more effectively together. In order to achieve this, the following steps are needed:

- (1) define the roles and responsibilities of the three Secretariat levels;
- (2) create standard operating procedures to facilitate collaboration and joint work;
- (3) strengthen intercountry, interregional work and global centres of excellence distributed across regions to serve as sources of support.

113. The following table is a first step towards clarifying roles and responsibilities to eliminate duplication and increase synergy, efficiency and effectiveness.

#### **Country level**

##### *Technical cooperation*

Lead the provision and brokering of technical cooperation with Member States through the development of a country cooperation strategy; and identify areas requiring technical support and institutional strengthening.

##### *Policy advice and dialogue*

Provide policy advice and lead policy dialogue at country level, as well as facilitating broader engagement of countries in regional and global policies and dialogues.

##### *Norms and standards*

Support countries in adapting guidelines, tools and methodologies for country use and implementing global norms and standards.

##### *Knowledge generation and sharing*

Support the collection, analysis, dissemination and use of national data (including surveillance data, country experience and trends) in support of monitoring the global health situation, and support research.

##### *Convening*

Convene and coordinate health actors in support of national health developments and in response to public health emergencies.

#### **Regional level**

##### *Technical cooperation*

Provide technical support for the development of country cooperation strategies and backup for

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	institutional strengthening at country level; foster technical cooperation among countries; lead collaboration with Member States that have no country office.
<i>Policy advice and dialogue</i>	Provide platform for sharing policy advice, and contribute to the development of global policies and strategies, provide backup to country offices on policy advice and dialogue; and advocate on regional health matters.
<i>Norms and standards</i>	Develop or adapt guidelines, methodologies and tools; adapt global strategies to the regional specificities.
<i>Knowledge generation and sharing</i>	Regional aggregation and validation, analysis, dissemination and use of health-related data (including surveillance data) and trend analysis; comparative analysis of and lessons learnt from regional country experiences, and sharing good practices on issues of region-wide concern.
<i>Convening</i>	Convene regional governing bodies and regional and inter-regional health platforms; facilitate Member States' engagement in regional initiatives and coordinate with regional and sub-regional entities.
<i>Enabling</i>	Provide backup on administrative and managerial issues for country offices.
<b><u>Headquarters</u></b>	
<i>Technical cooperation</i>	Provide backup for country offices on technical issues and support institutional strengthening at country level.
<i>Norms and standards</i>	Lead in the formulation of technical norms and standards; develop methodologies, tools and global strategies.
<i>Knowledge generation and sharing</i>	Global consolidation, dissemination and use of health-related data (including surveillance data) and global trend analysis; research and innovation on issues of global significance; and broker inter-regional exchange of experience and lessons learnt.
<i>Convening</i>	Convene global governing bodies; convene key stakeholders for global health initiatives, and lead in shaping the health agenda at global level.
<i>Policy advice and dialogue</i>	Formulate global public health policies; coordinate strategic global public health goods, and advocate on global health matters.

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*Enabling*

Develop policies, systems, and oversight and accountability frameworks for administrative and managerial issues.

114. Increasing the effectiveness of response requires greater clarity about the *relationship* between parts of the Organization (in other words, *how* they work together) as well as clarity about the roles and functions that each level performs (in other words, *what* they actually do). With regard to relationships, the essential shift is from vertical hierarchy to horizontal networking, while strengthening the accountability of each office. In practice this will mean growth in the working relationships between regional offices, and between groups of country offices within and across regions (for example, WHO Representatives in the BRIC countries – Brazil, Russia, India and China – share many common interests). Such a shift will mean that, although the regional offices continue to provide technical and administrative support to country offices, the country offices will have a greater degree of independence in relating to headquarters and to other centres of expertise.

115. As relationships become more inter-dependent there is a greater need for clarity in the division of labour. Similarly, aspects of transparency and accountability have heightened importance, both in financial terms and in regard to people's comprehension of what different parts of the Organization are doing.

116. The next programme budget will present a more detailed breakdown of functions and outputs at each level, thus providing the framework for accountability that is needed for the alignment between the three levels to work effectively,

**Strategic relocation of programmes and operations**

117. The location of critical programmes and operations will be reviewed against three sets of criteria. First, there is a balance to be struck in locating technical support close enough to where it is needed, while at the same time maintaining collaboration with other programmes and ensuring a critical mass for professional development. The establishment of technical hubs of expertise that provide support to countries with similar needs is a practical expression of this idea. Some such hubs have been established (e.g. in vaccine manufacture); others will be considered.

118. Second, not all global functions need to be carried out in headquarters. Current examples include the role of the European Office in managing relationships with the institutions of the European Union on behalf of the whole Secretariat.

119. Third, location must be judged on the basis of cost-effectiveness, e.g. shifting functions (both technical and administrative) to lower-cost sites. This will complement other measures to increase organizational effectiveness, in areas such as travel and publications. Further work is needed to analyse fully the cost and strategic implications of shifting organizational locations.

**Improve knowledge management**

120. Staff need to be able to access up-to-date information on what the Organization is doing, on a wide range of technical issues, and on how to access relevant expertise. This is particularly critical at country level when requests from national authorities need a rapid response and cannot wait for transmission of the request and the answer through the hierarchy. Harnessing tools for handling and disseminating knowledge requires neither new structures nor great expense. It does, however,



represent a powerful means of increasing organizational effectiveness and is therefore included here as a priority.

### **Recommendation**

*The Board is asked to endorse the overall approach to increasing organizational effectiveness and to identify proposals for further development by the Secretariat.*

## **Financing**

### **Summary of proposals**

121. Six areas for improvement are addressed: collective financing of agreed priorities with more predictable, sustainable and flexible income; a contingency fund; financing of administration and management; a revised income and expenditure structure; financial controls; and Organization-wide resource mobilization.

### **Background**

122. The financing of WHO's work has evolved over time. There is now a gap between what the governing bodies approve in terms of strategic direction and budget for the Organization and the resources actually made available. Effective financing is only a means to an end and needs to build on a clear vision for the Organization, focusing on its core functions. The objectives for a more effective financing of WHO must be based first on strengthening effective governance. The governing bodies need to take full ownership and responsibility both for approving WHO's priorities and objectives as well as for negotiating and ensuring full financing. Other objectives include transparency and accountability; alignment of the total budget to the agreed objectives and expected results – not only individual contributions; improvement of predictability and flexibility, linked to effective human resource management and the possibilities of implementing the broader reform agenda; improvement of risk management and financial controls; and a move from project financing to programme financing. The key challenges to effective financing of WHO are detailed below.

123. The current level of assessed contributions is not sufficient to carry out WHO's work.<sup>1</sup> Voluntary contributions are the major source of the Organization's funding<sup>2</sup> and are expected to remain so. Voluntary contributions are often highly specified and not fully aligned with the programme budget. The majority of WHO's funding is not sufficiently predictable or sustainable. There is an imbalance of funding for different programmes between technical cooperation and normative work, and between staff costs and activities.

124. The cost of the staff through whom the Organization carries out most of its work, constitutes more than 50% of expenditures, which is expected for a knowledge-based organization. For the 2010–

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<sup>1</sup> Assessed contributions account for approximately 25% of funding in the 2012-2013 Programme Budget.

<sup>2</sup> Voluntary contributions account for approximately 75% of funding in the 2012-2013 Programme Budget.

2011 biennium, approximately 45% of the programme budget was financed with a reasonable degree of certainty at the beginning of the biennium.

125. WHO also lacks sufficiently flexible voluntary contributions to reprogramme funds if there is an imbalance in contributions, and to move money around quickly to address emerging needs and priorities.

126. WHO's role in public health and humanitarian emergency risk management and control, inclusive of the International Health Regulations (2005), is unique in the world. As recommended by the International Health Regulations Review Committee,<sup>1</sup> WHO needs to establish a contingency fund for public-health emergencies.

127. The costs of WHO's administration are not adequately financed. A key income stream currently used to underwrite these costs is through a programme support cost levy on voluntary contributions. However, while the official rate of programme support cost is 13%,<sup>2</sup> earnings effectively average just below 7%. A supplementary income stream derives from the component of post occupancy charges. Even the combination of these two streams is still insufficient to finance the budgeted administrative costs.

128. Another issue for WHO's financing is the challenge posed by the mismatch between currencies of expenditure and currencies of income, which can carry significant financial risks in an environment of rapidly fluctuating exchange rates.

129. Although many financial controls exist, the current approach does not systematically assess risks and is not always consistently applied across the Organization.

130. Finally, the Organization's approach to resource mobilization is not always coordinated. The lack of clearly defined priorities and approaches to donors makes it difficult for some parts of the Organization to take advantage of resource mobilization opportunities. Some have developed strategies of their own and successfully raised significant funds, but others have not, and there is a need for an Organization-wide approach.

## ***Proposals***

### **Increase predictability of financing and flexibility of income**

131. An aim of reform is to increase the percentage of the Organization's budget that is predictable (before the beginning of the biennium) to at least 70%. The following approaches are proposed for securing these targeted proportions of predictable income. This will enhance WHO's ability to effectively and efficiently deliver according to its agreed priorities and lead to greater transparency and accountability for results and resources.

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<sup>1</sup> See document A64/10.

<sup>2</sup> Standard programme support cost as per resolution WHA34.17, excepting monies for non-emergency and emergency supply services (lower rate established in resolution EB33.R44) and pass through monies (e.g. for bulk pharmaceutical procurement via WHO-administered partnerships).

(1) Institution of a *collective financing approach* designed to secure a shared commitment by Member States and other donors to fully finance the Organization's priorities as agreed by Member States in the programme budget.<sup>1</sup> This approach is predicated on an inclusive, proactive, systematic, coordinated and transparent process to ensure predictable financing and characterized by the following features and sequence of events: an inclusive process of Member State priority-setting is initiated at the Health Assembly for the next programme budget based on a review of past annual results and expenditure; once priorities are agreed and costed for the programme budget, a *financing dialogue* is held with all interested Member States and non-state donors (on a voluntary basis) after the Health Assembly, led by the Programme, Budget and Administration Committee, with the objective of securing sufficient collective financing for the programme budget. The Secretariat conducts continuing and systematic resource mobilization with existing and new donors to address any residual gaps. At the same time, the Secretariat actively follows up donors to realize pledges made, with regular updates given on operational performance and financial resource requirements through a dedicated web site.

(2) Sustained efforts to increase the number of multi-year framework agreements with donors.<sup>2</sup>

132. Given the greater accountability and transparency for results and resources that will stem from the new collective financing approach, it is proposed that Member States and other donors increase the proportion of WHO's income that is flexible by providing voluntary contributions that are less specified i.e. linked to higher level strategic components of the programme budget either through the existing core voluntary contributions account<sup>3</sup> or relatively soft earmarking.

### **Recommendations**

*The Board is asked to endorse the direction above. The Board is also asked to request the Secretariat to analyse further the feasibility and mechanics of the collective financing approach, including cost implications, as well as evaluating the feasibility of acceptance by donors of a shift towards more multi-year framework agreements and increases in flexible contributions, for presentation to the Board at its 130th session in January 2012.*

### **Establish a contingency fund for public health emergencies**

133. A contingency fund will be established, based on the recommendations of the International Health Regulations Review Committee, to be used for activating the immediate response in a public health emergency. The fund will be open to contributions from Member States and other donors. The Secretariat will prepare a detailed proposal for the special fund covering the rationale, feasibility,

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<sup>1</sup> The previously used term "replenishment model" was confusing, as it inadequately described the proposed concept. The concept of a collective financing approach is fundamentally different from the replenishment model used by the GAVI Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria, World Bank and other financing instruments.

<sup>2</sup> Baseline = 8

<sup>3</sup> Baseline = 7% of WHO's income in 2010-2011.

design elements, legal and due-diligence measures to manage conflict of interest and reputational risk, cost implications and timeline for establishment. The proposal will be presented to the Programme, Budget and Administration Committee in May 2012.

### **Recommendation**

*The Board is asked to endorse the direction above to enable the Secretariat to provide the more detailed proposals described.*

### **Improve financing of administration and management costs**

134. The Secretariat should ensure sufficient and transparent funding for effective administration and management by enforcing adherence to the programme support costs that have been agreed by the governing bodies.<sup>1</sup>

135. The Secretariat is defining, for implementation in 2012, a central control and oversight system to monitor agreements for adherence to programme support costs for voluntary contributions and to ensure that all project proposals submitted to potential donors include administrative and managerial costs.

136. The Programme, Budget and Administration Committee should commission a detailed analysis of the actual costs of administration and management within the Organization and make recommendations on how these should be financed.

137. The Secretariat will review and optimize current internal cost-recovery mechanisms.

### **Recommendation**

*The Board is asked to review the direction above, modify it as appropriate and endorse it.*

### **Protect against currency fluctuations**

138. In addition to current measures such as currency hedging to protect the Organization against fluctuations in currency exchange rates that can negatively affect income and expenditure, WHO will consider the following measures:

- (1) increase Swiss Franc income by securing the agreement of donors to pay in Swiss Francs (ideally, by switching some or all of assessed contribution invoicing to Swiss Francs, but also by payment of voluntary contributions in this currency);

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<sup>1</sup> Standard PSC as per Resolution WHA34.17, excepting monies for non-emergency and emergency supply services (lower rate set by Resolution EB33.R44) and pass-through monies (e.g., for bulk pharmaceutical procurement via WHO-administered partnerships).

- (2) introduce an annual “budget re-costing” mechanism to adjust WHO’s budget for major currency movements, as is the practice in some United Nations organizations;
- (3) reduce Swiss Franc costs by reducing the size of the Secretariat staff at headquarters (e.g. redeploy staff to lower-cost duty stations).

### **Recommendations**

*The Board is asked to review the direction above, modify it as appropriate and endorse it. The Secretariat will prepare further details, including cost-benefit analyses, for presentation to the Board through the Programme, Budget and Administration Committee in May 2012.*

### **Strengthen financial controls**

139. During 2012 WHO will develop an enhanced control framework that comprehensively addresses financial control requirements for critical administrative processes. This control framework will include the following elements: description and purpose of control; identification of individuals with responsibility for control; monitoring effectiveness of control; escalation and corrective measures in case of breaches of control.

140. The control framework will also provide a more systematic approach to risk evaluation, which will help management and auditors monitor the effectiveness of key controls. The development of the enhanced control framework requires these steps: development of a risk-assessment framework; documentation of standard operating procedures across all offices, identifying control points that help the Organization mitigate risks; clarification of the accountability of decision makers, including via delegation of authority, and the consequences for non-compliance; ensuring that administrative officers, managers or other staff with financial-management responsibilities have the required competencies and support for their functions; and institutionalization of periodic, joint administrative and technical reviews of compliance across the Organization.

141. The following areas are proposed for priority action under the enhanced control framework: donor agreements, travel expenses, hospitality expenses, human resources clearance on staff separation and human resources entitlement administration.

### **Recommendation**

*The Board is asked to review the direction above, modify it as appropriate and endorse it.*

### **Improve Organization-wide resource mobilization**

142. The aim of an improved resource mobilization approach will be to strengthen the effectiveness of resource mobilization activities linked to the new collective financing approach through:

- (1) informed, consistent and coordinated approaches to donors based on defined Organization-wide priorities and clear roles within and across the three levels of the Organization;
- (2) Organization-wide forecasts of funding needs and targets;
- (3) enhanced capacity for effective resource mobilization, particularly at country level;
- (4) an expanded and strengthened donor base through approaches to new and emerging donors;
- (5) strengthened implementation, reporting to donors and strategic communications.

### **Recommendation**

*The Board is asked to review the direction above, modify it as appropriate and endorse it.*

## **Human resources**

### **Summary of proposals**

143. Five areas are addressed: a revised workforce model to address the mismatch between financing and sustainable staffing; recruitment and selection; performance management processes; a framework for mobility and rotation; and staff development and learning.

### **Background**

144. There is currently a mismatch between financing and sustainable staffing. The workforce is not aligned with Organizational funding. The current human resources policy encourages staff to seek long-term employment with WHO, while the Organization's funding is largely for short-term projects. In some areas the Organization relies on a single funding source. More troubling is that programme delivery for specified funds is in some cases subsidized by the Organization's core activities to ensure implementation. Further, the costs associated with staff reassignment or separation make it difficult for WHO to respond quickly to emerging needs and to stop functions, and create financial liabilities that are not adequately covered in programme budgets. The Organization requires greater flexibility to manage staffing effectively.

145. Staff are hired for specific projects, but the staffing model does not then allow for flexible changes; the proportion of flexible funding does not match core staff needs; there is no overall global approach for workforce planning across the three levels of the Organization; and joint planning and joint programming require strengthening.

146. Recruitment of staff is overly complex and lengthy.

147. The performance management development tool is not sufficiently used for evaluating staff performance and development and taking actions accordingly.

148. Practices for mobility and rotation of staff across all levels of the Organization are insufficiently implemented and widely divergent.

149. There is a lack of proper orientation for new staff; and there is no framework for learning from successes and failures at all levels of the Organization.

### ***Proposals***

#### **Revise work force model and contract types**

150. A new workforce model will distinguish long term functions for which predictable funding is required from time-limited projects which will be linked to short-term funding. Human resources planning will be totally integrated into the planning and budgeting process to ensure that staffing structures are appropriate for the results planned and the income expected to be available, both in the shorter and longer terms. Contract types will be revised to match Organizational priorities and financing mechanisms.

151. The Secretariat will initiate the following action steps during 2012–2013:

- (1) determination of which functions are long-term and which are time-limited. This will require, among other things, defining for the two types of function: eligibility criteria, competencies, contract benefits and entitlements, employment duration and geographic distribution;
- (2) alignment of appropriate funding streams with each type of function;
- (3) development of a mapping of longer-term functions at all levels of the Organization, in line with Organizational priorities, realignment and financing.

#### **Streamline recruitment and selection processes**

152. The Secretariat will streamline recruitment and selection processes, with faster turnaround times, in the following ways:

- (1) creation of more generic and standard post descriptions in a phased manner through 2012, which will increase consistency throughout the Organization, reduce position classification time and facilitate mobility and rotation of staff;
- (2) development of standard operating procedures to help harmonize recruitment policies and to increase the speed at which hiring takes place.

#### **Improve performance management processes**

153. The Secretariat will improve performance management processes to underpin a high-performing culture based on excellence and accountability. In addition to the current system, staff will be evaluated through a more comprehensive feedback process, together with a policy for reward, recognition and addressing underperformance.

154. A pilot performance management process was initiated in 2011. Based on outcomes of the pilot, the Secretariat will then phase in a new Organization-wide performance management system.

### **Implement a mobility and rotation framework**

155. A framework for mobility and rotation has been piloted in the Regional Office for the Western Pacific. To complement this work the Secretariat will conduct analyses on the costs and other implications for the framework. The next step will be to establish mobility periodicity for staff by function and location. This will include developing an incentive policy to encourage movement and ensure that mobility is an essential minimum requirement for employment eligibility at the professional level.

### **Enhance staff development and learning**

156. The Secretariat will enhance and harmonize staff development and learning across the Organization, with a priority placed on country level.

157. The Secretariat will establish a skills and competencies inventory framework. This will be complemented by an online career path mapping tool, linked to job types and projected vacancies.

#### **Recommendation**

*The Board is asked to endorse the direction above.*

### **Results-based management**

#### **Summary of proposals**

158. The proposals address five areas for strengthening the current results-based management system: a clear results chain; a realistic budget; revised time frames for planning and implementation; country-driven planning; and a new resource allocation mechanism.

#### **Background**

159. Results-based management was first introduced in the programme budget for the biennium 2000–2001, which was structured around approximately 30 areas of work. Following that early experience, a revised planning framework was introduced in 2006, based on a six-year medium-term strategic plan, with 13 strategic objectives, linked to a 10-year general programme of work for the period 2006–2015. The results-based management framework was incorporated into the Global Management System, which was implemented from 2008.

160. The current planning framework is complex, consisting of four layers: a general programme of work; a medium-term strategic plan; a programme budget; and operational plans. The linkages are weak between the higher layers of planning; it is difficult to see how the priorities in the general programme of work are reflected in the medium-term strategic plan and the programme budget.

161. Inconsistencies in the results chain (for example as a result of the lack of clarity in formulating the organization-wide expected results, office-specific expected results, and their respective indicators), and challenges in measuring and attributing the contribution of the work of WHO to health outcomes, have led to a lack of clarity in defining and measuring results. Consequently, WHO has



found it difficult to communicate clearly what contribution the Organization makes to specific improvements in health outcomes and health impact. It has also been difficult to demonstrate the impact of reduced levels of financing on the achievement of strategic objectives and expected results.

162. Accountabilities are unclear, as there is no direct link between accountability for results (as formulated in the strategic objectives, office-specific expected results and organization-wide expected results) and accountability for resources (as recorded by the budget centres). The move to a matrix approach led to a weakening of some technical networks that had previously supported areas of work.

163. The programme budget is largely aspirational and has not functioned adequately as an accountability mechanism. There is a lack of clear explicit connection between resources, outputs and outcomes, and outputs are not costed uniformly.

164. WHO lacks a robust process to ensure that priorities guide resource allocation between outcomes, functions and levels of WHO. The process of planning is cumbersome and time consuming for budget centres. The cycle of planning is lengthy and does not sufficiently support the process of assessment and evaluation to make the planning periods fruitful. The results of the evaluations conducted have had relatively little impact on improving this aspect. Planning is largely top down and supply driven, and is not always aligned with country needs, nor does it always involve technical staff. Joint planning is not followed by joint programming. The programme budget covers just two years yet preparation has to begin far in advance of each budget period. Further, there are too many layers of planning and staff have to spend significant periods of time on inefficient planning processes.

165. The current resource allocation mechanism is linked to a “validation mechanism” that assesses the distribution of funds between the major offices, including headquarters. For regions, allocation is based on a set of criteria that are now regarded as not sufficiently fair, rational or transparent.

## *Proposals*

### **Implement a new results chain**

166. A new results chain, based on commonly agreed terminology, is shown below. A standard set of indicators will form the basis for monitoring and evaluation of impact, outcomes and outputs. These will be organization-wide at the impact and outcome levels and specific for country offices, regional offices and headquarters at the output level. The number of impacts, outcomes and outputs will be reduced compared with existing numbers of strategic objectives and expected results. Each level of planning will be monitored using predetermined methodologies and at specified time points. The time points will depend on the periodicity established for each level of planning.

<b>Results Chain</b>	<b>Definition</b>
Impact	The highest-level change (usually, a sustainable change in the health of populations) to which WHO (Secretariat and Member States) has contributed. For example, improvement in the health status of a population through: a decrease in morbidity and mortality; elimination or eradication of a disease; or a decrease in prevalence of risk factors.
Outcome	The work to which the Secretariat is expected to contribute and against which its performance will be measured through changes, primarily in institutional capacity and behaviour in countries. For example, coverage of

	an intervention or health system performance, such as: vaccine coverage; treatment coverage; and access to care.
Output	What the Secretariat intends to deliver to influence institutional capacity and behaviour in countries and for which it will be held accountable. For example, tangible products and services at each level of the Organization, such as: legal frameworks and normative standards (headquarters); regional health strategies (regional offices); and increased national capacity for surveillance (country offices).
Activity	The processes that turn inputs into outputs.
Input	The resources (human, financial, material and other) that the Secretariat will allocate to producing the outputs.

167. During the development of the next general programme of work and programme budget, impacts and outcomes will be formulated and agreed by Member States. The next programme budget will be guided by this framework and will include information on the contribution of each level of the Organization to the results chain and also encompass the outputs for country offices, regional offices and headquarters. For timing, see the section below on a “revised planning framework”.

### **Revise the planning framework**

168. Different time frames for planning and implementation are needed. A longer horizon for commitments by Member States and donors would improve planning. The current periodicity is ten years for the general programme of work, six for the medium-term strategic plan and two years for the programme budget. To increase accountability and transparency on performance and to streamline planning, proposals for change are to:

- (1) increase the period covered by the programme budget to three years;
- (2) subsume the medium-term strategic plan within the general programme of work;
- (3) change the time frame for the general programme of work to encompass three programme budget cycles.

169. Within any given programme budget period, there will be an annual budget and results review, including any adjustments to be made to the programme budget, for review and discussion by the Programme, Budget and Administration Committee. This will not only allow for timely programmatic and budgetary adjustments in line with accurate income and expenditure projections but will also ensure that monitoring and reporting to the governing bodies, for greater accountability and oversight, is more frequent and allows for better engagement of Member States than is currently the case.

170. The next steps are to develop the next programme budget and general programme of work and present it to the Health Assembly. An important factor for the development of the general programme of work will be agreement on the level of detail required. Subject to a decision by the Member States at the special session of the Executive Board in November 2011 on the periodicity of the programme budget, development of the next budget will be based on the following proposal: the programme budget will be developed as a working document in 2012 for discussion with Member States during regional committees and further developed based on Member State inputs. The Programme, Budget

and Administration Committee and the Board will discuss the revised document in January 2013, with proposed adoption by the Health Assembly in May 2013 (substantial Member State inputs during the session of the Board in January will be incorporated in the version presented to the Health Assembly in May).

### **Sequence planning to reflect country needs**

171. The Organization's planning must better reflect the needs of countries. A revised planning process is required to ensure that country needs drive planning more strongly, and to create greater coherence among plans at all three levels of the Organization.

172. Planning from 2012 will follow three interrelated, iterative and sequenced processes to contribute to the development of the programme budget: (1) individual country-level planning based on the country cooperation strategies and national health sector plans; (2) regional-level planning and consolidation of country-level plans at the regional level; and (3) headquarters-level planning. The planning timeline will be aligned with the agreed timeline for development of the next programme budget.

### **Prepare a realistic budget**

173. Member States have requested that WHO's budget be based more on realistic assumptions of projected costing of outputs, income and expenditures, and less aspirational. The programme budget will be based on accurate costing of outputs, expenditures and income. Approaches to standardized *costing of outputs* will be developed. *Expenditures* will be based on current and projected exchange rates, rates of inflation, staff and non-staff cost assumptions, and future planned activities. Projections of *income* will be based on the current economic situation, trends in international development assistance for health and the historically of previous contributions by Member States and other donors.

174. The Secretariat will take the following key action steps:

- (1) develop standardized costing of outputs based on standard costs for other common non-staff inputs and activities during 2012;
- (2) monitor and report on income and actual expenditures to ensure that development of the next programme budget is guided by realistic projections.

### **Create a new resource allocation mechanism**

175. A new resource allocation model is needed to better reflect changing Organizational priorities and needs. Important prerequisites for the development of a new resource allocation mechanism will be: (1) clarification of the roles, responsibilities and synergies of the three levels of the Organization; (2) a clearly defined result chain highlighting the work of the Organization at its three levels; (3) a realistic budget; and (4) accountability by the resource allocating body and the implementing level of the Organization.

## **Recommendations**

*The Board is asked to take a decision on changes in the periodicity of the programme budget (from two to three years), and for the general programme of work to subsume the medium-term strategic plan and to cover a period of nine years (three programme budget cycles). The Board is also asked to endorse the proposals for a new results chain and a realistic budget. The Board may wish to request the Secretariat to propose a new resource allocation mechanism through the Programme, Budget and Administration Committee in May 2012.*

## **Accountability and transparency**

### **Summary of proposals**

176. Five areas for improvement are addressed: monitoring and reporting; internal control framework; audit and oversight; conflict of interest; and information disclosure.

### **Background**

177. Member States expect stronger performance assessment from WHO. The Global Management System, one tool for accountability, contains a wealth of information.

178. However, there is inadequate analysis of this information. There are insufficient reports that contain validated results and are timely, consistent and meaningful, and that include assessment of resources and expenditures compared with the budget.

179. The audit and oversight system has limited capacity. The Office of Internal Oversight and Services has a broad mandate, but is insufficiently resourced to provide a comprehensive, risk-based approach to audit and oversight.

180. Member States' accountability and means to measure their commitment to joint targets and priorities remain ambiguous.

181. When compared with the information provided to individual donors, there is a relative lack of timely, validated information about results and resources to provide to the Member States and governing bodies. Reports to individual donors provide more financial details, and more detailed assessments of results achieved, than routine reports to the governing bodies.

182. Although many policies and procedures for internal accountability are already in place, there is no single, easily accessible repository in a standard format; this contributes to poor compliance. Policies are often developed and disseminated through various channels without plans for orientation or compliance, and without a clear division of responsibilities.

183. Enforcement of current control mechanisms is not robust. Most of the needed policies are in place, but compliance and monitoring of compliance are fragmented and can be improved. Responsibilities within the current matrix planning framework (through the strategic objectives and major offices) is not clearly defined across the Organization, which leads to ambiguity in accountability for results and resources. The "business owners" of organizational policies have only a

limited mandate to monitor and enforce them. As a result, managers and staff responsible for applying and complying with these policies may not have a full understanding of them.

184. Current policies on conflicts of interest and information disclosure are insufficient to deal with growing complexities in global health.

## **Proposals**

### **Improve monitoring and reporting**

185. The Organization will strengthen accountability to Member States through more accurate and detailed reporting of results and resources. Mechanisms will be established for improved monitoring of programme planning and implementation, and financial and human resource management by WHO senior managers, at all levels of the Organization.

### **Strengthen internal control framework**

186. The internal control framework will be strengthened and linked to roles and responsibilities assigned to staff, with routine monitoring of compliance and management action for breaches of compliance.

### **Increase capacity of audit and oversight**

187. In line with the recent audit reports,<sup>1</sup> plans are well advanced to increase capacity for audit and oversight. Increased capacity will enable increased frequency and broader coverage of internal audits.

### **Strengthen conflict of interest policy**

188. The overall conflict of interest policy will be strengthened. This will include the guidelines for declarations of interest for WHO experts, issued in June 2010, the process to assess staff conflicts of interest, and measures to address institutional conflicts. An Ethics unit will be established to oversee ethical conduct of staff, and administer the declaration of interest policy and procedures.

### **Establish an information disclosure policy**

189. An information disclosure policy will be developed, to include policies on publication of internal policy documents (such as whistleblower, harassment and investigation policies) and information (such as internal audit reports, financial disclosures, etc.).

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<sup>1</sup> See documents EBPBAC14/3 and A64/30.

### **Recommendation**

*The Board is invited to endorse the direction above.*

### **Independent evaluation**

#### **Summary of proposals**

190. Two areas are addressed: an evaluation policy; and a mechanism for oversight of evaluation by the governing bodies.

#### **Background**

191. Evaluation is a crucial function at WHO and is carried out at all levels of the Organization. Evaluation makes an essential contribution to the work of WHO, reinforcing accountability to key stakeholders, and promoting institutional and individual learning. Periodic comprehensive independent external evaluation can play a significant role in improving the performance of international organizations, and supporting organizational development. WHO appears to be one of the few United Nations agencies that does not have an evaluation policy endorsed by its governing bodies, nor routinely make its evaluation reports public.

192. Evaluations of the work of WHO are currently commissioned and conducted at three levels; at the United Nations system level (by the United Nations Joint Inspection Unit), Organization-wide (by the Office for Internal Oversight Services), and at a decentralized level (by individual WHO programmes). WHO does not have an established mechanism for the WHO governing bodies to commission and oversee such evaluations.

193. Many external evaluations are commissioned and conducted by individual partners or groups of partners. These may be limited to WHO, or may encompass other agencies within and outside the United Nations system. Recent examples include the Multilateral Organization Performance Assessment Network, and the United Kingdom Multilateral Aid Review. Results of these assessments are usually publicly available.

194. Evaluation is separate from, but related to, the essential accountability function of routine monitoring of performance and resource utilization. Evaluation is an ongoing function, and an integral part of each stage of the programming cycle, with an evaluation plan developed as part of the WHO planning and budgeting cycle. Formative evaluation is designed with the purpose of improving and developing programmes, whereas “summative” evaluation assesses the effects or outcomes of programmes.

195. WHO lacks an established mechanism for oversight of evaluation by the governing bodies. Many programmatic evaluations are carried out each year, but there is a lack of systematic follow up on the recommendations of evaluations—follow up that would contribute to organizational learning and knowledge management.

## **Proposals**

### **Develop an evaluation policy**

196. The policy will be based on best practice and applied to all evaluations commissioned by and conducted within the Secretariat. Work to formulate a policy is in progress and will be submitted to the Executive Board.

### **Establish a mechanism for oversight of evaluation by the governing bodies**

197. There are several institutional arrangements through which the governing bodies could commission, provide oversight and conduct independent evaluations of the work of WHO. These would be sustainable, effective, rapid, not resource-intensive, and have significant impact and influence. The proposed arrangements are:

- (1) the Board would commission and provide oversight for evaluations, approving terms of reference, endorsing selection of independent experts to conduct the evaluation, approving the work plan, and receiving and considering the evaluation report;
- (2) expand the mandate of the Office of Internal Oversight and Services. The Board would review and approve the programme of work of evaluation of the Office, and receive and consider evaluation reports;
- (3) establish a separate Evaluation unit. The Board would need to establish a separate body that would report to it directly.

198. The Board at its 129th session requested the Secretariat, inter alia, to develop a concept note on independent evaluation of the work of WHO.<sup>1</sup> Based on feedback on the concept note, the Secretariat prepared and distributed draft terms of reference for independent evaluation of a thematic area of work of WHO for further consideration by Member States. It is clear that Member States have yet to reach consensus on the scope, timeline, oversight and what group should carry out the evaluation. The Secretariat therefore proposes the following options:

- (1) the Board could commission an independent evaluation as presented in the concept note and draft terms of reference;
- (2) implement a two-stage approach, consisting first of a high-level independent review on financing, fiduciary control, staffing and country offices, followed by a comprehensive independent review of WHO core functions, governance, staffing and sustainable financing.

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<sup>1</sup>See decision EB129(8).

### **Recommendation**

*The Board is invited to take a decision on the options for a mechanism of oversight of evaluation by the governing bodies.*

## **Strategic communications**

### **Summary of proposals**

199. Areas addressed are: communications capacity; platforms for communications; and stakeholder understanding of WHO's work.

### **Background**

200. Health remains a top agenda item in many forums and a prime public and political concern around the world. An increasingly complex international health architecture, the emergence of new players influencing health decision making, a growing demand from the public and politicians alike to demonstrate clearly the impact of the Organization's work, and the emergence of new global health challenges, all make evident the need for effective and coordinated communications.

201. WHO sometimes appears fragmented—an expert in multiple fields, but unable to project a coherent sense of the Organization and its achievements.

### **Proposals**

#### **Build communications capacity**

202. WHO will build and deploy its communications capacity through improved coordination across the Organization, increasing efficiencies in the way communications functions are delivered, developing surge capacity for deployment in emergencies to any location where it is needed, aligning better with resource mobilization and donor stewardship, and developing standard operating procedures for emergency communications as well as continuously improving the communications skills of staff.

#### **Develop communications platforms**

203. WHO will develop effective and cost-efficient platforms for communications, enabling staff and partners to communicate success stories that describe the impact of WHO's work, use champions and spokespersons effectively, use social media wisely, be proactive in reaching out to and educating the media, invest in technology for broadcast and web-based media outreach and ensure that more multilingual communications materials reach a broader audience in Member States.

#### **Improve public and stakeholder understanding of the work of WHO**

204. A regular system of measuring public and stakeholder perception and needs will provide important input into the development and periodic review of a comprehensive Organization-wide communications strategy. Reputational risks will be managed more vigorously through a strengthened



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communications surveillance system for early warning, proactive response, and joint work with United Nations and other partners on shared concerns.

**Recommendation**

*The Board is invited to endorse the direction above.*

**CONCLUSION**

205. The reforms described in this document are ambitious, and designed to deliver real, measurable and sustainable improvements in the way WHO works and is financed. The proposed reforms are not homogenous; some are already being implemented, others can be acted on relatively quickly, while some require more detailed consideration and planning. Several have significant resource implications which must be carefully considered.

206. An overview of the proposed road map for WHO reform is provided in document EBSS/2/INF.DOC./1, with several examples of timelines for specific proposed reforms. Successful implementation of the proposed reforms will require a detailed plan, with specific objectives and indicators to track progress, and detailed costing. Based on the decisions of the Board, the Secretariat will develop a detailed implementation plan for WHO reform, for consideration by the World Health Assembly in May 2012.

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