WHO reform:

Programmatic reform – focus on results

Programmatic and financing reforms continue to strengthen the Organization’s planning, budgeting and financing cycle towards more effective and efficient delivery of Member State-agreed outputs and to contribute to improved health outcomes.

The key outcomes of programmatic reforms are: (i) needs-driven priority-setting, result definition and resource allocation aligned to the delivery of results; (ii) improvement of the delivery model at the three levels of the Organization to better support Member States; (iii) adequate and aligned financing to support strategic focus; and (iv) transparent reporting of results delivery and use of resources.

The attached working paper describes the progress made over the past years in the programmatic reform areas at the global and regional levels.

The High-Level Preparatory (HLP) Meeting held in the WHO Regional Office in New Delhi from 29 June to 2 July 2015 reviewed the attached working paper and made the following recommendations:

**Actions by Member States**

1. Continue to closely involve the Secretariat in the planning process for Programme Budget 2016–2017 to identify tangible results for WHO collaborative work which will be peer-reviewed from 21–23 July 2015;

2. Consider allocation of resources to the already identified priority areas to the extent possible, 70–80%, while finalizing the 2016–2017 country workplans; and

3. Consider providing adequate attention and resources to the regional flagship initiatives at country level.

**Actions by WHO**

1. Ensure linkages among the flagship areas, and country as well as global priority areas as much as possible; and

2. Revise the working paper on programmatic reform incorporating the inputs from the discussions at the HLP meeting.

The revised working paper and other recommendations of the HLP are submitted to the Sixty-eighth Session of the Regional Committee for consideration.
Background

1. Four years since the decision of the Executive Board to establish a Member State-led reform process in May 2011, the Secretariat has made significant advances towards meeting the objectives of being a more effective, efficient, transparent and accountable Organization that plays a stronger role in global health governance and puts to better use its relative strengths to improve health outcomes.

2. WHO reform has three broad aims: (1) programmatic reform to improve people’s health; (2) governance reform to increase coherence in global health; and (3) managerial reform in pursuit of organizational excellence.

3. Progress made and reported to Member States over the past four years across the three streams of reform, including the financing reforms that were triggered by the global economic downturn, substantiates the conclusion that, broadly speaking, WHO is a stronger organization today than it was at the outset of the reform process.

4. Specific reforms continue to proceed step-wise and with varying pace of implementation. In May 2014, the Sixty-seventh World Health Assembly noted the report by the Director-General describing the restructuring of the reform results framework that arose from the recommendations of the second stage evaluation. Since then, the percentage of outputs that have reached the implementation stage has increased from about 40% in January 2014 to about 80% to date.

5. The greatest progress has been made in the area of programmatic reforms in terms of developing focused programmes and priority-setting, with all expected outputs having reached the implementation stage.

Progress in programmatic reforms

6. Programmatic reform involves explicit priority-setting and a strengthened technical delivery model. Priorities have been defined and addressed in a systematic, transparent and focused manner. Aligning technical and financial resources concurrently is essential to the effective and efficient delivery of these priorities, as well as to avoid an overcommitted and overstretched Organization.

7. Programmatic reforms along with financing reforms would continue to strengthen the Organization’s planning, budgeting and financing cycles towards more effective and efficient delivery of need-based, Member State-agreed outputs while contributing to improved health outcomes.

8. The key outcomes of programmatic reforms are: (1) needs-driven priority-setting, results definition and resource allocation aligned to delivery of results; (2) improvement of the delivery model at the three Organizational levels to better support Member States; (3) adequate and aligned financing to support strategic focus; and (4) transparent reporting of results delivery and use of resources.
Needs-driven priority-setting, results definition and resource allocation aligned to delivery of results

9. The journey of programmatic reforms started with the development of the Twelfth General Programme of Work (GPW), endorsed by the Sixty-sixth World Health Assembly in 2013. It set the vision for clear articulation of objectives and expected results that rely on the correct identification and prioritization of both country needs – where most results are delivered – and issues of strategic importance at the global level. They feed into WHO’s resource allocation mechanisms and ensure that the Organization focuses on areas of greatest need and impact.

10. Further simplifying the Organization’s planning processes, the former 10-year GPW was shortened to a six-year GPW. This medium-term document helped the Organization to dispose of another medium-term strategic plan. The Twelfth GPW covers the period 2014–2019, containing three biennial programme budgets. Under the Twelfth GPW, 2014–2015 had been the first biennium, while 2016–2017 would be the second.

11. The Twelfth GPW specifies the change in the results chain of the Organization, which was a fundamental step in programmatic reforms.

12. It identifies 30 programme areas, grouped under six categories: (1) communicable diseases; (2) noncommunicable diseases; (3) promoting health through the life course; (4) health systems; (5) preparedness, surveillance and response; and (6) corporate services/enabling functions.

13. A range of programme areas are identified under each of these categories, against which the biennial operational planning is undertaken. This has helped the Organization to minimize vertical programmes working in watertight compartments. In addition, the regions have been provided with flexibility to manage budget ceilings within each category, making the budget ceiling management simpler and more flexible.

Improvement of the delivery model at the three Organizational levels to better support Member States

14. With clear priorities and expected results, the Organization can determine a more systematic approach to deliver programmatic work effectively and use financial, human resources and informational resources efficiently. Achieving this would require improvements in
WHO’s delivery model on the basis of a clear definition of roles and functions at the three Organizational levels and planning allocation of resources in consonance with this model.

15. Programme Budget 2016–2017 and operational plans were the first to be developed, in line with the bottom-up planning process through engagement at the three Organizational levels, involving rigorous consultations with Member States for over a year.

16. The first step was to identify the priorities for WHO’s technical cooperation at the country level. A structured process of consultation with Member States and other stakeholders at the country level was put in place to further streamline and sharpen the focus of the work of the Organization with agreed priorities.

17. WHO country offices identified priority sets of up to 10 programme areas for WHO’s technical cooperation at the country level, to which approximately 80% of resources for the technical areas (Categories 1–5) would be directed; the remaining 20% being employed to meet existing commitments and emerging priorities during the biennium.

18. The second step was to review the priorities at country offices, regional offices and headquarters, taking into account a number of elements, including existing commitments and engagement with partners; global and regional action plans and targets; and resolutions adopted by the governing bodies. The priority results and deliverables at each level of the Organization were consolidated by the three levels through the programme area, with oversight from the category networks and the Global Policy Group.

19. The iterative process took into account emerging priorities based on the following components: resolutions adopted by the governing bodies; implementation of Programme Budget 2014–2015; and the recent experience in responding to the Ebola virus disease outbreak. These components further shaped Proposed Programme Budget 2016–2017. The process provided the opportunity to break from setting priorities based on historical precedents and to focus resources on areas in which WHO has more potential to contribute to health outcomes.

20. An additional step was introduced in the process to validate the work proposed and ensure that the budgets reflected the human resource needs.

**Adequate and aligned financing to support strategic focus**

21. Funding must be broad-based, predictable, stable and strategically aligned to the Organization-wide priorities. Adequate funding allows greater focus on results delivery, improved attractiveness for talents and greater internal efficiency.

22. The introduction of the Financing Dialogue as part of WHO’s financing reforms has demonstrated significant impact in improving the financing of WHO and targeted and coordinated Organization-wide resource mobilization.

23. Predictability of funding has increased by about 20% from the start of the biennium in 2014–2015 as compared to 2010–2011. A slight improvement in the flexibility of funding has been noted.
24. Financing reforms of WHO have facilitated the WHO Regional Office to strategically allocate flexible funds available to it (including core voluntary contributions and assessed contributions) to fund country priority programmes including regional priorities.

25. Strategic use of flexible resources brings together several key aspects of resource management and the Programme Budget. More details on the funding gaps across the Organization are becoming apparent earlier in the biennium, as a result of detailed analysis of current and future resources by programme area against the Programme Budget.

**Transparent reporting of results delivery and use of resources**

26. Effective and transparent reporting of the activities and achievements of the Organization are conducive to building trust in its relevance and ability to deliver. This increases the likelihood of WHO’s guidance and information being taken up and also creates the conditions for adequate funding in the future.

27. It has been proposed that the Organization’s work be measured through the indicators identified against each output in the Programme Budget 2014–2015 document.

**Regional perspective**

28. During the development of the regional Programme Budget 2016–2017, the first step was to identify the priorities for WHO’s technical cooperation at the country level in each of the Member States. A structured process of consultation with Member States and other stakeholders at the country level was followed to identify up to 10 priority programme areas for WHO’s technical cooperation in each of the 11 countries of the Region.

29. Approximately 80% of resources for the technical areas (categories 1–5) would be directed at these country priorities; and the remaining 20% at meeting existing commitments and emerging priorities during the biennium.

30. These country priorities were reviewed at the Regional Office, taking into account regional priorities, existing commitments and engagement with partners; regional action plans and targets; and resolutions adopted by the governing bodies.

31. Seven regional flagship priorities for SEAR have been identified, based on a set of criteria. These include the country priorities as reflected in the WHO Country Cooperation Strategies (CCS), the magnitude of the burden of disease in SEAR countries as indicated in the Global Burden of Disease Report 2010, the Regional Committee resolutions of the past five years, outcomes of the individual meetings of the Regional Director with the Hon’ble Ministers of Health, Deputy Ministers as well as technical experts in Member States. The criteria also included areas where specific, targeted results could be relatively easily achieved (for example, making the Region free of certain neglected tropical diseases, such as kala-azar, lymphatic filariasis, leprosy, yaws, and schistosomiasis). These criteria have helped to identify the regional flagship priorities in the short and medium term.

32. These regional flagship priorities are in line with WHO’s global leadership priorities and form a sub-set of WHO’s programme priorities. The regional flagship priorities are: (1) measles
elimination and rubella control by 2020; (2) prevention of noncommunicable diseases through multisectoral policies and plans with focus on “best buys”; (3) the unfinished MDG agenda: ending preventable maternal, newborn and child deaths with focus on neonatal deaths; (4) universal health coverage with focus on human resources for health and essential medicines; (5) building national capacity for preventing and combating antimicrobial resistance; (6) scaling up capacity development in emergency risk management in countries; and (7) finishing the task of eliminating diseases on the verge of elimination (kala-azar, leprosy, lymphatic filariasis yaws and schistosomiasis).

33. The programmatic emphasis for Programme Budget 2016–2017 for the Region was developed on the basis of the continuing and emerging needs of the SEA Region. These include: (i) application of lessons learnt from the regional emergencies; (ii) response to the discussions on the post-2015 development agenda, with a focus on universal health coverage; (iii) accelerating progress towards elimination/control of vector-borne diseases; (iv) expanding the work on prevention and control of noncommunicable diseases, including mental health and ageing; and (v) emerging threats and priorities, including viral hepatitis.

34. In developing the regional Programme Budget 2016–2017, 70–80% of the regional resources will be broadly directed to the priority areas and the remaining funds allocated to areas which are WHO’s mandated responsibilities.

35. The bottom-up planning and budgeting process contributed to further refinement of a realistic proposed programme budget to accurately reflect expected costs for agreed deliverables at country and regional levels – an important prerequisite to ensure that the Programme Budget functions as the primary tool for accountability for WHO Budget Centres.

36. The principles of programmatic reforms would be further positioned at the country level to ensure that the Programme Budget continues to serve as the primary tool for not only programming WHO’s work, but also to become the basis for measurement of WHO’s performance through its delivery of outputs and the instrument against which WHO’s resources are mobilized and managed.