WHO reform: programmes and priority setting

Programmes and priority setting in WHO

1. In decision EB130(6), the Executive Board at its 130th session decided on the scope and terms of reference for a Member State-driven process and requested the Director-General to prepare materials in support of that process.\(^2\) The present document responds to the request for a summary of current priority-setting practices in WHO, their strengths and weaknesses, and the relationship between the country cooperation strategies, the formulation of the general programme of work and the programme budgeting process.

2. The document is organized in three parts. The first provides a conceptual overview of priority setting in WHO, starting with a short glossary of terms. The second then looks at priority setting in practice from the general programme of work through to operational planning. The third suggests points for discussion at the meeting, organized around the objectives set out in decision EB130(6).\(^3\)

OVERVIEW

Glossary

3. The scope of work of the Member State-driven process is to make recommendations to the Sixty-fifth World Health Assembly on the categories, methodology, criteria and timelines for programmes and priority setting in order to serve as guidance to the development of the next and future general programmes of work, recognizing the important linkages to other elements of the WHO reform process.

4. To facilitate discussion, the following terms correspond to those used in document EB130/5 Add. 1 and decision EB130(6).

\(^{1}\) And, where applicable, regional economic integration organizations.

\(^{2}\) See also documents 2, 3, and 4, which respond to paragraph (2)(b) of decision EB130(6).

\(^{3}\) See decision EB130(6), paragraph (1)(b).
Core functions: describe “how” WHO works (e.g. by providing technical support, setting norms and standards). Core functions derive directly from Article 2 of the WHO Constitution and are therefore relatively fixed even if the substantive technical focus of WHO’s work changes over time.

Criteria: are factors to be taken into account in determining priorities. Different sets of criteria are used in developing priorities for different purposes, for example in developing the general programme of work including strategic objectives, the programme budget and the country cooperation strategies.

Methodology: used in priority setting describes how different criteria are used quantitatively or qualitatively in reaching decisions about priorities. An explicit methodology makes priority setting more objective, systematic and transparent.

Priority setting: relative weight given to categories and functions in light of predefined criteria applied through a given methodology to make decisions on greater programmatic emphasis and special consideration in terms of resource allocation.

Timeline: describes the relationship between different planning instruments and the sequence of consultation and levels of approval that precede their final adoption. The timeline for preparing the next general programme of work and programme budget is set out in a separate document.¹

Process

5. The ultimate operational expression of WHO’s priorities for a particular biennium appears in the biennial programme budget. That budget is informed by the strategic direction contained in a general programme of work which, in turn, is influenced by the objectives and functions set out in the WHO Constitution.

6. Article 1 of the WHO Constitution defines the overall objective of the Organization as the “attainment by all peoples of the highest possible level of health”. Article 2 then categorizes WHO’s work into 22 “functions” that the Organization should carry out in order to achieve that objective.

7. The Constitution articulates the broad scope of WHO’s work; the 22 functions combine what are described above as functions (e.g. to promote and conduct research in the field of health) and substantive technical topics (e.g. to foster activities in the field of mental health).

8. The next step in the process is the development of a general programme of work. Article 28 of the Constitution requires that the Executive Board “submit to the Health Assembly for consideration and approval a general programme of work covering a specific period”. Neither the form nor the periodicity of the programme of work are specified. Some general programmes of work have been brief, others much more extensive. They also vary as to whether they seek to set a health agenda for the world or to set out a broad outline of the Secretariat’s work to be carried out in collaboration with Member States.

9. The Eleventh General Programme of Work 2006–2015 focused strongly on articulating a global agenda for health. There was thus a need for an additional instrument to provide the strategic guidance

¹ See document 4.
for the work of WHO. This took the form of a medium-term strategic plan (MTSP), covering three bienniums from 2008 to 2013.

10. The development of the MTSP and the programme budgets derived from it are informed by WHO’s global obligations, regional priorities and WHO country cooperation strategies.

11. The country cooperation strategy is a medium-term vision for technical cooperation with a given Member State, in support of the country’s national health policy, strategy or plan. It is WHO’s key instrument to guide its work in countries and the main instrument for harmonizing WHO cooperation in countries with that of other United Nations organs and development partners.

12. The figure below provides a schematic representation of the current planning framework. It shows at country level the relationship between the WHO country cooperation strategy and national health priorities and plans.

**Figure: WHO planning framework**

PRIORITY SETTING IN PRACTICE

**General programme of work**

13. The current, Eleventh General Programme of Work covers the period 2006–2015 and is explicit in setting out a “global health agenda” for all stakeholders, providing a long-term perspective on challenges to health and the measures required to overcome them. Priorities for WHO itself receive relatively little attention.

14. The Eleventh General Programme of Work organizes the global health agenda around seven priorities:
15. It also lists the criteria that were used in arriving at this agenda:

- the current health situation including demographic changes and trends in the global burden of disease;
- current investments in health and strengths and weaknesses of current health systems;
- the rapidly changing environment of international health partnerships;
- the challenges to health, in particular, the gaps in the international response;
- existing international declarations and agreements including the Millennium Development Goals.

16. The Eleventh General Programme of Work also identifies six core functions of WHO in contributing to the achievement of the global health agenda:

- providing leadership on matters critical to health and engaging in partnerships where joint action is needed;
- shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge;
- setting norms and standards, promoting and monitoring their implementation;
- articulating ethical and evidence-based policy options;
- providing technical support, catalysing change and building sustainable institutional capacity;
- monitoring the health situation and assessing health trends.

17. The Eleventh General Programme of Work was developed over a two-year period of intensive consultation with Member States, globally and regionally, as well as with a variety of other stakeholders. The methodology used was consensus building around the global health agenda.
The strength of the Eleventh General Programme of Work lies in the degree of consensus achieved during the process of consultation. However a number of weaknesses are equally evident and provide useful pointers for how the process of priority setting at this level can be improved.

Firstly, the broadly defined global health agenda gives little sense of what WHO (in terms of the Secretariat working with Member States) aims to achieve. The individual points in the agenda are not readily measurable. To be of greater use therefore the general programme of work needs to give a sense of WHO’s “compact” with the world, indicating clearly what will be achieved by investment in the Organization.

Secondly, as a framework for more detailed priority setting, the global health agenda does not readily relate to the way work is organized in WHO itself, in health ministries or other health partners.

Lastly, the Eleventh General Programme of Work does list five categories of work (in the sense used in the glossary) for WHO itself. These provided a starting point for work on a medium-term strategic plan, but have otherwise had little impact. They are:

1. providing support to countries in moving towards universal coverage with effective public health interventions;
2. strengthening global health security;
3. generating and sustaining action across sectors to modify the behavioural, social, economic and environmental determinants of health;
4. increasing institutional capacities to deliver core public health functions under the strengthened governance of ministries of health;
5. strengthening WHO’s leadership at global and regional levels and supporting the work of governments at country level.

Medium-term strategic plan 2008–2013

The Eleventh General Programme of Work dealt primarily with a global health agenda. An additional instrument was therefore needed to provide strategic guidance more specifically for the work of WHO. This took the form of a medium-term strategic plan, covering three bienniums.

While the intended starting point was the five categories above, in practice the MTSP was organized around a larger number of categories — initially sixteen — which ultimately became the thirteen strategic objectives. These have been used since 2008 as the organizing categories of successive programme budgets.

Criteria for establishing strategic objectives were endorsed by the Executive Board in 2006:  

---

1 See documents EB118/7, paragraph 15, and the summary record of the fourth meeting, EB118/2006/REC/1.
(1) the global health agenda, as articulated in the Eleventh General Programme of Work;

(2) needs of Member States identified through country cooperation strategies, epidemiological surveys and analyses of the burden of disease;

(3) major health challenges of global and regional importance and relevance, as identified through discussions, decisions and resolutions of the Health Assembly and regional committees;

(4) equity, efficiency and performance, and support to countries in greatest need, in particular least developed countries;

(5) the advantage of WHO compared to other organizations, building on the objectives and core functions of the Organization;

(6) potential for measurable impact within a medium-term strategic planning period.

25. In practice, however, the methodology used for establishing strategic objectives was equally influenced by the need to group and create greater synergy between the 36 areas of work around which work had been previously been organized.

26. Unlike the Eleventh General Programme of Work, the MTSP does identify the specific health impacts, together with indicators and targets, for each strategic objective to be jointly achieved by Member States and the Secretariat over a six-year period. In addition, the MTSP provided tentative resource envelopes for each strategic objective for the six-year period. However, these were derived more by aggregating existing funding estimates for pre-existing areas of work than by using explicit criteria for determining the relative priority of each strategic objective. In addition, setting priorities between strategic objectives relied on guidance from Member States at the time of proposed programme budget deliberations (see also below).

27. Priority setting is also needed within each strategic objective. Thus the MTSP identifies a series of organization-wide expected results (OWERs) for each strategic objective. In this regard, the delineation of OWERS represents a form of priority setting. However, OWERS were arrived at based on obligations established through World Health Assembly resolutions or other international agreements, expert consultation on best practice, or negotiation between strategic objective coordinators at different levels of the Organization, but without recourse to explicit criteria or methodology. In terms of priority setting they tended to accommodate existing work rather than provide a means for increasing focus.

28. Results in the MTSP mix outcomes, in terms of changes in capacity or behaviour of Member States, with the specific contribution or outputs of the Secretariat. However, for the most part the targets are expressed in terms of the number of Member States achieving a particular outcome, rather than identifying ways of judging the performance of the Secretariat.

29. For country operations, the MTSP structure was often seen to be too complicated and did not easily align with the priorities established in the country cooperation strategies. For many staff it was seen as being more relevant to headquarters operations than to country needs. The theoretical relationship that is set out in the figure below, between the country cooperation strategy and other instruments, has not always been realized in practice.
30. In summary, the MTSP was needed primarily because of the limitations of the Eleventh General Programme of Work. If future programmes of work are more comprehensive — and specifically, if they define a clear strategic direction, high level technical priorities and an overall results framework for WHO working with its Member States — then a separate medium-term plan becomes redundant. Adjustments in terms of criteria for refining technical priorities and in terms of budgetary allocations within and between categories such as strategic objectives, are better managed in the context of the programme budget.

**Programme budget**

31. The programme budget covers the entire work of the Organization funded through both assessed and voluntary contributions. Only the assessed contributions of the Member States are decided at the time that the Health Assembly approves the Programme budget, however, voluntary contributions are established through individual donor agreements, the majority of which are signed during the period of implementation. The current structure of the programme budget around 13 strategic objectives mirrors that of the MTSP.

32. Specific criteria have been used to establish priorities in each biennium based on feedback from Member States and a review of performance over the previous budgetary period. For the Programme Budget 2012–2013, Member States requested that the budget figure be more realistic and in line with the level of forecast income. To this end the initial budget presented to the Executive Board in January 2011 was reduced by 20%, with accompanying reductions in the results expected to be achieved. In making revisions the following criteria were used:

(1) overall priorities expressed by Member States, in particular Millennium Development Goals 4 and 5, prevention and control of noncommunicable diseases, and the ability to respond to acute onset emergencies;

(2) programme areas that have the biggest impact on peoples’ lives, in particular in low- and middle-income countries;

(3) programme areas where the WHO Secretariat has a comparative advantage in executing its core functions;

(4) the nature of the work to be performed by the Secretariat, in particular work which requires a high level of direct country support is more directly impacted by reduction in budgets;

(5) maximizing opportunities to leverage work of other health and development partner agencies;


33. A key concern in using explicit criteria to reduce the overall total of the programme budget was to protect relative levels of spending on strategic objectives 3 and 6 (related to noncommunicable diseases); 4 and 9 (related to child and maternal health and to nutrition, food safety and food security) and 10 (related to health system strengthening).

34. The strength of the programme budget process is that it provides an opportunity to review and redirect the work of the Organization. Directions from Member States can be translated into criteria
for adjusting resource allocation between categories. A similar process has also been carried out at regional level.¹

35. Weaknesses in terms of priority setting mirror those already identified for the MTSP. While the country cooperation strategy development process has brought considerable clarity and greater focus to country cooperation there is no systematic link between the priorities identified and the categories around which the programme budget is organized. As a result there is a mismatch between the country cooperation needs that are expressed in the country cooperation strategy and the programme budget that is approved.

36. Secondly, because of the limitations (discussed above) of how results are formulated (mixing outputs and outcomes), the programme budget in its current format does not provide a clear sense of priorities within each strategic objective.

37. Lastly, results are not formulated in a way that facilitates performance monitoring. Specifically, it is not currently possible to differentiate between, and assess WHO’s performance in addressing the needs of individual countries, and its performance in its more normative role.

Operational planning

38. Priority setting and resource allocation are most closely linked at the stage of operational planning. It is at this stage that resources are allocated between strategic objectives and levels of WHO.²

39. Even when costs and priorities can be identified accurately, however, there is no guarantee that funding will be available. This is in part due to the specified and unpredictable nature of much of WHO’s financing. This discrepancy is most apparent in the operational planning process where the Organization’s activities and human resource plans are developed in detailed work plans. To ensure that the Organization is being financially responsible and operating within its means, the initial budget allocations are established based on an analysis of the level of funds likely to be available.

40. The result at an operational level is that the realized level of funding (as opposed to the projected amount on which initial allocations are based) becomes an important arbiter of priority setting and of what actually gets done. This is true at all levels of the Organization, but can cause particular difficulties at country level where explicit priorities have been agreed as part of the country cooperation strategies, but funds or personnel may only be available for some strategic objectives and not others.

41. Where possible, flexible sources of funds such as assessed contributions and core voluntary contributions are directed towards priority areas. However, the total amount of flexible resources is not sufficient to support all the Organizational priorities. This means that specified voluntary contributions are needed in order for the Organization to be able to deliver the expected results. This works well in the cases where there is close alignment between the unfunded priorities of the Organization and the

¹ See for example document SPBA2/7 on Programmatic prioritization and resource allocation criteria, prepared for the Subcommittee on Program, Budget and Administration of the Executive Committee of PAHO at its second session in March 2008.

² More detail on resource allocation and the validation mechanism is contained in EB130/5 Add.1 and is not repeated here.
voluntary funds. However this does not always happen, and there are many cases where priorities are underfunded. The paradox that follows is that well-funded areas tend to become the most visible parts of the Organization’s work and that visibility in itself attracts more funding sometimes at the expense of agreed priorities.

POINTS FOR DISCUSSION

Categories of work

42. The preceding analysis suggests that categories of work (whether expressed as strategic objectives or other similar terms) are needed to provide a framework for more detailed priority setting. The analysis also suggests four principles that might guide their use: (a) categories are more valuable if they are used consistently throughout the levels of planning framework and as an organizing structure for all aspects of WHO’s work, (b) that they are linked to high-level results and help describe what WHO aims to achieve (in other words that they denote purpose and are not simply demarcations of structure); (c) they accommodate the different aspects of WHO’s work (responding to the needs of individual Member States as well as global and regional cross-cutting activities); and (d) to allow flexibility, particularly at country level, they need to be relatively few in number.

43. The background document EB130/5 Add.1 suggested seven categories for the next general programme of work. These are:

(1) Supporting the achievement of the health-related Millennium Development Goals (primarily Goals 4, 5 and 6) will bring together AIDS, TB, malaria, maternal and child health with a focus on integrated service delivery.

(2) Promoting risk reduction, prevention, treatment and monitoring of noncommunicable diseases, mental health, disability and injuries.

(3) Strengthening the structure, organization and financing of health systems with a particular focus on achieving universal coverage, strengthening human resources for health and increasing access to medical technologies including medicines.

(4) Surveillance of and response to disease outbreaks, acute public health emergencies and the effective management of humanitarian disasters.

(5) Work on health information, information systems, evidence for health policy making, innovation, research and monitoring of trends, to include analysis and strategies to address the social, economic and environmental determinants of health.

(6) Convening governments and other stakeholders and facilitating partnerships in line with WHO’s role as the coordinating and directing authority on international health work, with a particular focus at country level on the development of national policies and strategies.

(7) Establishing effective corporate services that enable the efficient functioning of the whole Organization.

44. An alternative approach would be to distinguish within this list the first four categories, which represent substantive areas of work, and which are therefore more easily linked to high-level results. The last three points may be better understood as core functions (describing how WHO works). The
three functions in the above list could also be further expanded to match the six core functions in the current general programme of work (see paragraph 16 above).

Criteria for priority setting

45. Criteria for setting priorities in WHO fall into two major categories. First, the need for cooperation with individual Member States, based on assessments of disease burden, capacity and national priorities as expressed in country cooperation strategies. Second, the collective will of Member States, as expressed in conventions, regulations and recommendations, adopted by resolution or decision of the WHO governing bodies, and in other intergovernmental bodies, such as the United Nations General Assembly. The Organization is also mandated to carry out certain work through interagency and other agreements, for example, with FAO under the Codex Alimentarius.

Collective decisions of Member States

46. The WHO Constitution describes several instruments available to Member States to formalize collective decisions on actions to be taken by the Organization. These include conventions and decisions (Article 19), regulations (Article 21), and recommendations (Article 23). These are reflected in the various conventions, regulations, codes, frameworks and global strategies and plans of action, as well as the resolutions and decisions adopted by the governing bodies, and mandate the Secretariat to carry out specific work in relation to these decisions. In some instances, the World Health Assembly has also adopted specific disease control, elimination or eradication targets.

47. Examples of collective agreements adopted by WHO governing bodies that continue to provide direction to the work of Member States and the Secretariat include the following:

<table>
<thead>
<tr>
<th>Collective agreements endorsed by the World Health Assembly</th>
<th>Adopted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conventions</td>
<td></td>
</tr>
<tr>
<td>(a) WHO Framework Convention on Tobacco Control</td>
<td>2003</td>
</tr>
<tr>
<td>Regulations</td>
<td></td>
</tr>
<tr>
<td>(a) International Health Regulations (2005)</td>
<td>2005</td>
</tr>
<tr>
<td>(b) International Classification of Disease (10)</td>
<td>1990</td>
</tr>
<tr>
<td>Codes</td>
<td></td>
</tr>
<tr>
<td>(a) International Code of Marketing of Breast-Milk Substitutes</td>
<td>1981</td>
</tr>
<tr>
<td>(b) WHO Global Code of Practice on the International Recruitment of Health Personnel</td>
<td>2010</td>
</tr>
<tr>
<td>Frameworks</td>
<td></td>
</tr>
<tr>
<td>(a) Pandemic Influenza Preparedness Framework</td>
<td>2011</td>
</tr>
</tbody>
</table>
### (e) Global strategies and plans of action

<table>
<thead>
<tr>
<th>Description</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Global health sector strategy on HIV/AIDS, 2011–2015</td>
<td>2011</td>
</tr>
<tr>
<td>(b) Global strategy to reduce the harmful use of alcohol</td>
<td>2010</td>
</tr>
<tr>
<td>(c) WHO strategy on research for health</td>
<td>2010</td>
</tr>
<tr>
<td>(d) Action plan for the prevention of avoidable blindness and visual</td>
<td>2009</td>
</tr>
<tr>
<td>impairment</td>
<td></td>
</tr>
<tr>
<td>(e) Global strategy and plan of action on public health, innovation and</td>
<td>2008 &amp;</td>
</tr>
<tr>
<td>intellectual property</td>
<td>2009</td>
</tr>
<tr>
<td>(f) Action plan for the global strategy for the prevention and control of</td>
<td>2008</td>
</tr>
<tr>
<td>noncommunicable diseases</td>
<td></td>
</tr>
</tbody>
</table>

48. WHO is also called upon to carry out work by other intergovernmental bodies, for example the United Nations General Assembly. The High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (September 2011) adopted a Political Declaration¹ which requests WHO to carry out work in several areas. Similarly, a resolution on Global health and foreign policy has been adopted by the General Assembly every year since 2009, and requests WHO to carry out further work in this area.

49. Further detail on global and cross-cutting work which can determine criteria is provided in a separate document.²

#### Criteria for WHO cooperation in and with countries

50. Country cooperation strategies have been developed for 145 countries. The current set of criteria to be considered at the February meeting of Member States are as follows:³

   1. opportunities for developing national capacities;
   2. potential for longer term impact on national goals and strategies;
   3. WHO’s comparative advantage and core functions;
   4. the magnitude of the challenges, vulnerability of particular social groups, and gaps;
   5. the country’s international commitments;

---

¹ United Nations General Assembly resolution 66/2.
² See document 2.
³ See document 3.
(6) national capacity for response to the health challenges;

(7) national capacity to provide support to other countries.

51. While the criteria are relevant to all countries, explicit cooperation agreements have not been developed for all Member States. As requested by the Board, an analysis of 144 country cooperation strategies is presented as a separate document. However, a more complete picture would, in addition, need to include an analysis of priorities for WHO cooperation in the remaining 51 Member States.

52. WHO provides an extensive evidence base to underpin priority setting. The primary source of WHO information on the global, regional and national disease burden is the Global Health Observatory, which has produced an annual publication *World Health Statistics* since 2005. The work of the Global Health Observatory is complemented by the *Global Burden of Diseases, Injuries, and Risk Factors Study*, a collaborative initiative involving WHO, the World Bank, and several academic institutions. This study included a more extensive analysis of the mortality and burden of disease attributable to 26 global risk factors using a consistent analytic framework known as comparative risk factor assessment.

**Methodology**

53. It is proposed that the general programme of work include a clear results chain and that the programme budget link outputs and outcomes to resources, along with a clear delineation of what is to be achieved by different levels of the Organization. If these conditions are fulfilled, the general programme of work can subsume key elements of the medium-term strategic plan and provide the necessary strategic guidance for the development of the programme budgets.

54. The intention is that the priorities established in the general programme of work and programme budget reflect the needs of all countries for WHO collaboration. The priorities set will be geared to countries’ individual needs as well as to the collective global and regional actions that affect groups of Member States. WHO’s effectiveness in both domains will be evaluated through the results chain.

55. There has been little previous use of systematic methodology in arriving at WHO’s priorities. More often the process has been to work through consultation to build a consensus around the relative importance of different criteria.

56. Use of a matrix approach offers one possibility for improving the process of priority setting. In this approach, each substantive technical programme area is examined against WHO’s most important core functions. Options for how such an approach might work will be illustrated in the presentation made prior to the meeting.

**Timelines**

57. The timelines for the development of the next general programme of work and programme budget are set out in document 4.

---

1 See document 3.