WHO delivering for results
Changing ways of working for effective and efficient delivery

Introduction

1. During consultations with Regional Committees on the proposed Programme Budget 2018-2019, Member States requested further details on various factors, including how priorities are set at all levels of the Organization and how these are costed, as well as considerations of efficiencies to influence the investments required and shape the programme budget, including how the Organization's performance is assessed against it. This paper serves to respond to these issues.

2. Development, implementation and assessment of the programme budget takes into consideration principles and practices drawn from the WHO reform process (see Figure 1). Accountability and transparency are at the centre of this approach. The programme budget, as the primary accountability tool of the Organization, is the basis for planning, financing, and resource mobilization.

3. Further improvements are clearly needed, but the gains made throughout the process of reform represent a comprehensive approach in tackling the programmatic, managerial and governance aspects underlying a more robust and balanced programme budget. For example, the reform tackles not only the criteria and process for priority setting, but also the budget, structures, and internal policies on resource allocation and financing that empowers the implementation of these priorities. The reform also establishes the basis for improvements in achieving greater efficiencies and better measurement of results, while strengthening accountability and transparency.

4. The following sections illustrate each of the aspects that are helping to shape the programme budget, particularly focusing on the definition of results, priority setting, costing of outputs, strategic management of flexible resources and achieving greater efficiencies.
Figure 1. Interlinked aspects of WHO reform shaping the programme budget
5. Setting priorities, a joint responsibility of the Secretariat and Member States, is essential for a more focused and effective Organization.

6. Although the push for improving prioritization is not new, the WHO reform process represents comprehensive efforts in relation to setting priorities for the work of the Organization. Not only did Member States establish the criteria for setting the high-level priorities for the GPW (EBSS2/1), but they also directed the Secretariat to focus the work at country level though a bottom-up identification of priorities (EB136/INF./3). Moreover, by approving the entirety of the programme budget beginning in the 2014-2015 biennium, and not just the part resourced through assessed contributions, the programme budget has become the primary basis for programming, and for resource allocation to priorities and how those priorities will be financed (A66/48).

7. The starting point is establishing the overall high-level strategic vision of the Organization through the General Programme of Work. A more detailed prioritization of work for the biennium is then done within the planning process for developing the programme budget. The process starts with the identification of needs and priorities for WHO technical cooperation at country level.

8. WHO’s approach to prioritization through the programme budget process is a dynamic two-way process, which combines both bottom-up and top-down approaches, involving three levels of the Organization, partners and Member States (Figure 2).

Figure 2. WHO’s iterative process for identifying priorities

- Sustainable Development Goals
- Global/Regional mandates/agenda (top-down)
- Priorities
- Country level need (bottom-up)
- Strategies, CCS, national plans
- 1 Current health situation; needs of individual countries for WHO support; Internationally agreed instruments including resolutions; existing evidence base; and WHO’s comparative advantage.
9. Table 1 illustrates the steps.

**Table 1: Overview of the process of prioritization for the programme budget**

<table>
<thead>
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<th>Step</th>
<th>Description</th>
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| 1    | WHA and UN GA resolutions, GPW, SDGs | • The GPW guides overall priority setting for WHO  
• The overall priority setting is also informed by WHA resolutions  
• SDGs set a new framework for the work of WHO |
| 2    | Identification of needs and priorities at the country level (bottom-up process) | • Priorities for country technical cooperation are identified in consultation with Member States and partners  
• Up to 10 priority programme areas are identified to which 80% of resources will be allocated  
• The process is informed by regional and global resolutions and strategies |
| 3    | Identification of regional and global priority work informed by country level priorities | • Regional offices and clusters at Headquarters develops their programme of work referring to country priorities and regional and global strategies and action plans; it is a dynamic two-way process |
| 4    | Validation and consolidation of priorities by Major Offices and the Programme Area Networks | • Coherence and consistency of country, regional and Headquarter priorities are reviewed together, and a consolidation into Organization-wide priorities, and results chain and deliverables articulated.  
• Validation against the Strategic Budget Space Allocation |
| 5    | Review of the priorities by the Major Office senior management and Category networks | • Overall strategic review of senior management of the priorities from the perspective of regional and global level.  
• Strategic review of category networks, including review of results chain, and metrics |
| 6    | Global Policy Group review and decision | • Overall strategic review by the Global Policy Group, including high-level review of issues and provision of advice on the finalization of the programme budget. |
| 7    | Regional Committee consultations | • Programme Budget with the programmatic priorities and budgets are reviewed by the Regional Committees  
• Individual consultations and briefings with Member States  
• Feedback and comments are taken into account in refining the priorities and budgets |
| 8    | Submission to Executive Board for consideration | • Adjustments made on priorities and budgets are taken into account in the programme budget submitted to the Executive Board. |
10. The WHO reform has led to substantial improvements in the way priorities are set for the programme budget. A structured process was put in place in 2014, for the development of the programme budget 2016-2017. At that time, only about half of country level were setting their priorities through the process outlined above. For 2018-2019, nearly all countries went through the structured process of prioritization and have identified a focused set of priorities.

11. Figure 3 shows an overview of the programme areas that were chosen as priorities at country level. The prioritization at country level shows the tendency to select the more mature programmes, and programmes with high visibility for WHO (e.g., NCDs, RMNCH, vaccine-preventable diseases) and health systems areas. Note that prioritization of the Health Emergencies Programme is not included in Figure 3. A separate process has been undertaken to consider factors specific to health emergencies, including ongoing emergencies in countries and a systematic assessment of countries’ risks and vulnerabilities.²

Figure 3. Number of programme areas prioritized at country level (Excluding Desk offices and reserves)

[Frequency chart showing the number of times each programme area was selected as a priority]
12. The approach explained above shows that the planning process is not purely bottom-up. A starting budget envelope is established at the beginning of the process for all Major Offices (regional offices and HQ). This serves as a validation mechanism which ensures bottom-up planning is within the expected budgetary envelopes. This makes the budget realistic and adheres to the Strategic Budget Space Allocation decision.³

13. Prioritization at country level is also a dynamic process. Therefore, WHO’s system has taken into account that changes can happen once the budget is in place. After the PB has been adopted, WHO holds a mid-term review exercise, budget centres are asked to re-examine the priorities identified during the planning phase to ensure that they continue to be relevant and reflect current reality. Budget centres are then encouraged to make necessary adjustments. The proposals for adjustments are reviewed in Major Offices and by the Global Policy Group before a final decision is made.

14. Through its prioritization process WHO is bringing coherence to the diverse interests and perspectives of Member States, technical partners and donors, and the work of the Organization as a whole.

Better defining results

15. To set priorities, the Organization needs to be clear about the results it wants to achieve. A key step in the programmatic reform was to define a clear results chain for the Organization as a whole. A clear results chain not only helps explain how the WHO’S work creates change and contributes to the ultimate goal of ensuring health lives and promote well-being for all at all ages, but also serves as an instrument through which WHO’s performance is assessed.

16. The Organization started to implement the new results chain in the programme budget 2014-2015. It was based on the standard results chain of the United Nations.⁴ The results chain links the work of the Secretariat (outputs) to the health and development changes to which it contributes, both in countries and globally (outcomes and impact). It provides a narrative that explains exactly how outputs combine to produce outcomes, and how outcomes combine in different ways to produce impacts. The basic logic of the results chain is illustrated in the diagram below.

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³ EB/137/7 Decision; and A69/47 Decision - As part of the WHO reform, a successful Strategic Budget Space Allocation (SBSA) exercise was conducted and approved by the World Health Assembly (EB/137/7 Decision; and A69/47 Decision). The four main segments considered in the SBSA, included: 1) Technical cooperation at the country level; 2) Provision of global and regional goods; 3) Administration and Management; 4) Emergency response. The outcome of the SBSA will be implemented gradually over our biennia starting in 2016-2017.

⁴ Results-based management Handbook, UNDG, 2011.
17. In each of the 31 programme areas, there is a well-defined outcome to which both the Secretariat and Member States commit. For each of the outcomes, outputs define the contributions of each of the three levels of the Organization. These contributions are reflected as deliverables, which clearly articulate the agreed ‘division of labour’ across the three levels.

18. The results chain reinforces the notion of one WHO, delivering as one. The results chain represents how every change at all levels of the Organization combine to create coherent and measurable Organization-wide outputs by programme area. These outputs ultimately contribute to creating sustainable changes in line with the Sustainable Development Goals.

19. However, WHO’s focus on the results chain should not be seen simply as a linear view of the causal relations between the Organization’s inputs and activities and the outputs produced. The interrelations and linkages of the activities and results demonstrate a network of influence, where outputs reinforce each other to contribute to different outcomes and impacts. For example, the work of prequalification of medicines, vaccines and diagnostics is a normative function that aims to bring more manufacturers into the market, while ensuring quality, particularly from developing countries, and to create lower prices. Lower prices help to stretch aid budgets, enabling countries to increase access to treatment to more people in need. A more complete theory of change explains how these leads to other effects, including the growth of emerging drug manufacturers and the strengthening of national regulatory authorities in those countries.

20. Having a simpler, clearer and unified results chain enables the Organization to: a) demonstrate the value of WHO’s contribution to achieving better health overall; b) communicate a coherent story as to how the Organization creates change that eventually leads to better health; c) better define and ensure accountability for results at each of the levels of the Organization and in its programmes; and d) better costing of results and better mobilization of resources to align with priority results.

21. The main challenge for the Organization in better defining results is determining and communicating a harmonized set of results for the entire Organization, and at the same time being able to account for the specificities that exist in countries, regions, and to measure and demonstrate these results clearly.
22. To achieve results, the investment by the Organization must be directed to priorities agreed by the Organization. This is why determining the costs for delivering the intended results is crucial.

23. The costing of the programme budget is closely tied to the process and the result of priority setting. The costs of producing the outputs of those priority programme areas shape the programme budget. Therefore, costing is imbedded within the process of developing the programme budget. It starts with the identification of the priorities and ends with the finalization of the budget.

24. The primary objective of costing is to be able to cost the inputs required to deliver the results, particularly at the output level. This is the level at which WHO is solely accountable for delivering.

25. In order to do this, the process was laid out so that assessment of priorities and the resources required to deliver them took into consideration country, regional and global contributions, as well as the costing of the governing body resolutions.

26. The costing is initiated at the budget centre level in country, regional offices and Headquarters. The costing is based on the budget centres’ estimates of resource requirements to deliver on the priority outputs in each of the priority programme areas. However, the identification of resource requirements (e.g., staff and activities) does not start from scratch. The previous biennium provides the starting point for the analysis of the required inputs (i.e., number, profile of staff and activities).

27. The overview of the process of costing is illustrated in Figure 4.

**Figure 5: Overview of the iterative process for costing the output**

- Identification of priorities at each of the levels of the Organization
- Consolidation of priorities into programme area results (i.e., outputs)
- Identification and confirmation of contributions of budget centre to Organization-wide results
- Estimating resource requirements (number of staff and activities)
- Costing based on standardized approaches (e.g., standard post cost averages, standard cost of goods and services)
- Consolidation of costs by budget centre, by programme, by category, by major office
- Development of the budget proposal (i.e., budget by output, by programme area, by category, by major office)
The key is establishing the resources required for staff and activities. This is deliberated and agreed with senior management in major offices. Resource requirements, i.e., staff and activities, are then determined. As part of the enhancement of the process of developing the programme budget, high-level human resource and activity planning has been advanced to inform the review of resource requirements for the development of the next biennium’s budget.

Once the resources required have been specified, each budget centre provides detailed costing using standardized approaches for staff and activities.

Staff cost is the single largest component of the inputs overall. WHO has a well-established approach for costing staff, which applies a standardized post cost average that takes into account several “building blocks”, i.e., the type of staff, grade, duty station, and other adjustment factors. The post cost averages are adjusted every biennium based on data from the previous biennium.

The detailed cost of activities and services are done during the operational planning. Cost drivers for activities vary, and so are the approaches to costing each of them. Standardized approaches exist for various types of activities, such as consultancy services, other service contracts, travel, goods, meetings, etc. These standardized costs, however, are highly dependent upon context and location.

For 2018-2019, the process is further enhanced through the introduction of early procurement planning based on the new procurement strategy and planning for duty travel.

The entire process is supported by a web-based tool used throughout the Organization. It supports prioritization, estimation of resources requirements, early human resource (including staff and non-staff) and activity planning and costing. The tool is used to enforce the available standard methodologies, e.g., post cost average, standard consultancy rates, catalogue of goods, etc.

The consolidated budget is reviewed by the Global Policy Group, which provides advice for its finalization. This is done with every budget submitted for the Regional Committee consultations, for the Executive Board and the World Health Assembly. For example, for the programme budget 2018-2019, a full costing of outputs by programme area and by category, with breakdown by staff and activities, has been provided in the Programme Budget Webportal.

Finally, after considering all inputs from Major Offices and outcomes of the consultations, the Director-General then makes the decision on the breakdown of the final budget submitted for approval by the Governing Bodies.

After approval of the programme budget by the WHA, one of the objectives of operationalizing it is to validate the costing of the outputs though a much more detailed planning for staff and activities. This is to ensure that the costing takes into account the most recent data on the cost drivers of the outputs for each of the programme areas. Therefore, the initial costing provided in the Programme Budget Webportal may change during operational planning, and will be updated at regular intervals.

The challenge in costing is standardizing the numbers of inputs that determine the resources required to deliver similar categories of outputs across the programme areas. For example, to produce norms and standards, the number of inputs, i.e. number and
level of staff and activities, will depend on complexity, time and the extent of the knowledge and evidence that already exists.

38. The outcome of the costing exercise contributes to realistic budget figures and is crucial for development by the Secretariat of budget proposals for fundraising purposes.

**Financing**

39. The three phase approach of WHO’s financing model is delineated as follows: it begins with a first phase where Member States determine the budget and priorities of the organization through the approval of the entirety of WHO’s programme budget; this is followed by a second phase with a Financing Dialogue meeting preceded and followed by bilateral meetings between the Secretariat and contributors; and a third phase of organization-wide resource mobilization efforts to fund the remaining gaps of funding.

40. The WHO Programme Budget has two separate segments; a base budget consisting of the six categories of work defined in the 12th General Programme of Work, namely Communicable diseases, Non-communicable diseases; Promoting health through the life course; Health systems; Health emergencies programme; and Corporate services / enabling functions. This base programme represents roughly three quarter of the total budget and is fully steered by the Health Assembly’s adoption of the programme budget. The other segment consists of the areas Polio, Tropical disease research; Research in human reproduction and Outbreak and humanitarian appeals. The figures presented in the programme budget for these areas are estimates, since their actual final budget is events driven and/or decided by separate governance mechanisms.

41. By approving the base budget, the Health Assembly sets ceilings for voluntary contributions to be raised by the Secretariat for the base budget. Unlike most national budgets where the approval of a budget and its financing are done by the same authority at the same time, the approval by the Health Assembly of the budget does not mean it is financed. Instead, it simply represents an authorization for the Director General to raise these funds (mostly from other sources such as other ministries in Member States) and spend them if available.

42. As a central element of WHO reform, the Health Assembly introduced a new financing model in 2013 through its approval of the 2014-15 programme budget\(^5\). The Health Assembly approved the entirety of the programme budget, rather than solely the assessed contributions (which currently represent only 21% of the budget). The approval of the programme budget by the Health Assembly represented an important shift from previous practice, in which only the proportion of the budget financed from assessed contributions was approved. Although the legal obligation for funding by Member States remains limited to assessed contributions, the change demonstrated a greater responsibility being taken by Member States for alignment of financing against the budget’s programmatic priorities, and increased accountability of the Director-General for its implementation.

43. In doing so, the Health Assembly:

   a) approved WHO’s two-year programme of work and performance measures;
   b) agreed on the total resources required to deliver that programme;

\(^5\) resolution WHA 66.2
c) allocated the total budget to WHO’s six categories of work;  
d) determined that the programme will be financed through a mix of assessed contributions and voluntary contributions; and  
e) decided on the amount of assessed contributions to be paid by Member States  
f) encouraged Member States and other contributors to support the programme budget further through voluntary contributions.

44. In terms of a financing vehicle, since 2013, WHO has deployed the mechanism of a Financing Dialogue to provide a platform for a conversation amongst Member States and other contributors on the financing requirements of the Organization and to promote the following principles:

a) Predictability: Predictable funding allows WHO to lengthen its planning horizon and is central to the overall management of the Organization. The standard indicator used by WHO to measure predictability is the percentage of funding against the requirements of the Programme Budget available to the organization at the outset of the biennium. At the beginning of the 2012/13 biennium, only 63% of funds required were available at the outset. By the start of the 2016/17 biennium the corresponding figure was 83%. Whilst this is a good result, “strong predictability” needs to be balanced by a measure of upwards flexibility to take account of any budgetary increases required to respond to Member State expectations. For the 2018/19 biennium WHO will be seeking to maintain this good performance but also ensure that funding is not so predictable that required increases cannot be accommodated.

b) Transparency: Transparency of decision-making and use of resources is a critical component of sound institutional relationship management practice. In this context, stakeholders have the right to expect WHO to be transparent in both its request for funds and for the use of resources provided. By the same token, WHO has a right to expect from contributors clarity around the rationale for funding decisions. Key developments in this area include the Programme Budget Web Portal providing full accountability on where money is raised from, where and for which programme area it is spent and what results are planned and achieved. Furthermore WHO has joined the International Aid Transparency Initiative IATI on 1 November 2016 and will provide all relevant information quarterly both to IATI and on the Web Portal as of April 2017.

c) Reduced vulnerability: The contributor base has started to broaden and some contributors are significantly increasing their contributions. Presently, 76% of voluntary contributions are paid by the top 20 contributors of voluntary contributions. For assessed contributions in accordance with the agreed scale of assessment the top 20 contributors provide 84% of all assessed contributions. WHO continues to encourage new and increased contributions. Since 2012-2013, WHO has brought on board 25 new contributors providing USD 500,000 or more. Half of them provide over USD 1 million and 3 over USD 5 million. WHO will be seeking to broaden the base further during the 2018-19 biennium.

d) Alignment and Flexibility: Given the balance of contributions where 80% of funding is earmarked to specific purposes, the issue of alignment and flexibility is key to ensure that all areas of the programme budget are financed to at least a minimum operating requirement and that gaps are minimised to the extent possible. In the 2014-15 biennium the alignment of funding to categories and programme areas improved mainly due to the strategic distribution of flexible resources, although these have been insufficient to compensate for all misalignments of specified voluntary contributions. This issue is discussed in further detail in section XX below:
45. The resource mobilization architecture is being strengthened in order to ensure better cohesion across all three levels of the Organization. A strategic networked approach, with a clearly defined resource mobilization cycle is being advanced. Resource mobilization will still be strengthened at all levels of the Organization, however, an enhanced common and collaborative approach is being designed, and all staff resource mobilization efforts will be directed towards achieving full funding of the approved programme budget. Resource mobilization plans of action aim to unite all three levels of the Organization around a common resource mobilization agenda, against the primary resource mobilization tool, the WHO Programme Budget.

**Strategic management of all resources**

46. The approval of the programme budget in its entirety also meant that the Organization needs to manage the entirety of the resources that finance it, and not by how the resources are mobilized.

47. The programme budget is financed through various sources of funding: from assessed contributions from Member States and from voluntary contributions from Member States, international organizations and non-State actors. The assessed contributions, and a small part of the voluntary contributions, i.e. core voluntary contributions and programme support costs, constitute the “flexible funding” of the Organization. We call these “flexible” because they are not earmarked for specific projects in specific countries or specific programme areas/health issues.

48. Flexible funding is an important source of financing for the Organization. In 2014-2015, the total amount of flexible funding was US $1.4 billion. It has been a steady source of financing for the work of the Organization.

49. A combination of changes made in the WHO reform, such as a more robust prioritization process, realistic costing of the budget, the approval of the budget in its entirety (the one budget principle), and the new financing model has put the Organization in a position to harness the potential of flexible funds.

50. Flexible funds have become an instrument used by the Secretariat to manage the entire set of resources that finances the programme budget. The new financing model, where the type of funding does not determine what is funded, has enhanced the strategic and leverage value of flexible funding.

51. The strategic value of flexible funding enables the Organization to invest in areas that provide the impetus for programmes to be able to implement a strategy or those that catalyse initiatives that achieve longer-term results. Flexible funds are used in areas that need initial investments to start implementing a strategy or global agenda (e.g., noncommunicable diseases). Flexible funds are also used to support areas where multi-year and predictable funding is needed to sustain work to achieve longer-term results (e.g., health systems/Universal Health Coverage). Flexible funding provides the ability of the Organization to make programmatic and budget decisions, not driven by funding made available by donors, but in areas that allow it to achieve the greatest impact.

52. The leverage value of flexible funding enables the Organization to correct the misalignment between the financing and the priorities set by Member States collectively. This misalignment is a result of a substantial specified financing flowing to a limited
number of programme areas, while other programme areas receive less donor interest. With a holistic view of the budget and the financing of it, the Organization is able to identify the most important programmatic and financial gaps based on an analysis of the distribution of the specified voluntary contributions. From a detailed analysis of the gaps, decisions are taken as to which gaps are most important so that programmes maintain their operational capacity. With the operational capacity secured, WHO’s programmes are in a better position to leverage resources to achieve intended results.

53. With the Organization being better able to identify the most important programmatic funding gaps (as demonstrated in the Webportal), it is able to make more effective allocation decisions for flexible funding.

**Figure 6: Flexible funding as a proportion of the total financing for technical categories, 2014-2015**

<table>
<thead>
<tr>
<th>Category</th>
<th>Specified VC</th>
<th>Flexible funds</th>
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<tbody>
<tr>
<td>Category 1</td>
<td>20%</td>
<td>80%</td>
</tr>
<tr>
<td>Category 2</td>
<td>32%</td>
<td>68%</td>
</tr>
<tr>
<td>Category 3</td>
<td>42%</td>
<td>58%</td>
</tr>
<tr>
<td>Category 4</td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td>Category 5</td>
<td>56%</td>
<td>44%</td>
</tr>
</tbody>
</table>

54. Greater efforts are being made to ensure more precise tracking of results from the allocation decisions by strengthening the links between financial and programmatic reporting. This will provide a better understanding of the adjustments needed on allocation decisions.

55. Therefore, strategic management of resources is the ability of the Organization to make allocation decisions more precisely as to where investments are most needed, what exactly is needed and when. The strategic management of flexible resources is the way in which the Organization is making use of flexible funding to secure the critical programmes and functions of the organization and use it to leverage resources to achieve intended results. This ability is a result of the advances made by the Organization in being able to see the entirety of the priorities based on needs; the entirety of the resources required to deliver on those priorities and their costs; and better clarity of the roles and responsibilities at each of the levels of the Organization.
56. The challenge is how to maintain a sufficient level of flexible resources, especially assessed contributions, which have the greatest strategic and leverage value.

**Efficient and effective delivery - Value for money**

57. Increasing health challenges and consequent expanding demands on the Organization, while maintaining at the same time the need to exercise budget discipline, means that the Secretariat has to operate effectively and efficiently.

58. Operating effectively and efficiency is central to WHO’s emphasis on accountability over resources. This means WHO achieving the results it intends to achieve in the most cost-effective manner.

59. Doing the right thing (i.e., effectiveness) and doing it properly (i.e., efficiency) does not mean only cutting costs. It minimizes cost where and when needed to invest in higher-impact activities. It maximizes outcomes where and when possible, given the resources it has been provided. This is what guides considerations of effectiveness and efficiency.

60. More needs to be done in this area, but the Organization has achieved many gains over recent years.

61. Policies and procedures are in place to ensure that the value for money and efficiency principles are followed for effectiveness and efficiency in the programmes. These policies and procedures relate to all main WHO cost categories, notably, staff costs and procurement. The introduction of the Global Management System (GSM) has brought significant progress in transparency, better monitoring of the use of resources, and has contributed to an improved managerial culture and better efficiency of administrative processes. GSM is now undergoing various enhancements designed to increase value for money, administrative efficiency, and operational effectiveness.

62. A comprehensive value-for-money plan is currently being developed and will be submitted to the governing bodies. It will examine all efficiencies, not only in administration and management, but also in the operations of technical programmes. It will examine different approaches and options, together with the implications of these, on the overall achievement of results and efficient allocation and use of resources to achieve these results. Thus, rather than the isolated and fragmented approach of cost cutting, it will demonstrate how WHO will achieve intended results by being able to optimize the use of its resources over time. In addition, some specific initiatives that have produced tangible efficiencies are further outlined below.

63. In Category 6, the following efficiency measures have been undertaken:

- **Cost control and reduction of administration and management costs.** Since 2009 WHO has progressively transferred administrative functions from Geneva to its Global Service Centre in Kuala Lumpur, with a resulting significantly reduced overall salary cost for these services. The cost reduction is due to the transfer of administrative functions from the headquarters in Geneva, Switzerland to the Global Service Centre in Kuala Lumpur, Malaysia. Functions now carried out at the Global Service Centre cover finance (payments, payroll), IT (help desk, system development), HR (contract processing), procurement (contract processing and goods purchase requisition management). These functions were previously located in Geneva. Staff costs in Kuala Lumpur, both for professional and general service, and applying the normal UN salary scales and grades, are much lower than Geneva, with savings estimated at **$31 million**
per biennium. (Since establishing the centre in Kuala Lumpur in 2009, salary differentials between Geneva and Kuala Lumpur have increased).

- **Outsourcing services in headquarters.** Almost all facilities management services have been outsourced, resulting in savings of approximately **$5 million per biennium**, taking into account the cost of staff previously employed with the cost of the facilities management contract.

- **Off-shoring functions.** In 2016, WHO took the decision to move functions from higher cost geographic locations to a lower cost one (off-shoring). In 2016, WHO moved functions related to human resources and procurement (i.e. Budapest office).

- **Increasing competition in procurements.** WHO is introducing a new online tendering portal to encourage increased bidding from suppliers for WHO contracts, and to allow for faster and more efficient comparison of bids. This system will lead to better pricing for many procurement contracts. Greater use of long-term agreements with strategic suppliers is also being implemented.

64. The impact of some of these efficiency measures is demonstrated in the overall reduction of the proportion of WHO’s budget spent on corporate and enabling functions, i.e., Category 6 (see chart below). The Organization is on track to significantly reduce the percentage of spending in this area in just over 5 years.

**Figure 7. Trend in percentage of spending for Corporate Services / Enabling Functions (Category 6) as a share of total expenditure**

65. This decrease has been achieved despite the additional investments made in certain functions, notably the increases in resources devoted to accountability and transparency (such as the creation of new compliance and ethics functions both in HQ and regions, and strengthening internal audit), and despite significant increases in security costs, including WHO’s contribution to the UN cost-shared security service.

66. In addition, there are previous initiatives from which the Organization continues to reap significant efficiency gains.

- **Centralization foreign currency purchases for WHO field offices.** This has paid significant dividends to WHO every year since 2012. In 2016, WHO saved **US $40 million in foreign exchange transaction costs.** This was achieved by shifting to a
centralized currency purchasing on behalf of country offices to meet local currency cash flow needs. The aim was to obtain more competitive foreign exchange rates for the purchase of local currencies that the country offices require. This system is now centrally purchasing 45 currencies in a series of transactions totalling approximately US $400 million under advantageous rates. These savings are recorded within the overall exchange gains for the year, and are apportioned to WHO funds in accordance with the Organization's financial rules.

- **Staff and other personnel costs.** In recent years, efforts to reduce the number of staff and re-prioritize staff positions have yielded cost savings. For example, staff and personnel costs as a percentage of total expenditure have been steadily reduced, falling from 47% in 2012 to 36% in 2015. This has been achieved by seeking to align human resources plans with priorities during the development of the programme budget, leading to increases in staff in country offices. Furthermore, the number of staff in senior positions, as a proportion of the total number, has decreased from 15.5% in 2005 to 12.2% in 2015 (P6/D1 and D2 positions together as a proportion of total professional staff).

This trend, however, may be adversely affected by the implementation of the new retirement age, which will cause a reduction in number of staff leaving through retirement, and consequent reduced ability to renew the workforce at potentially lower grades. WHO’s ability to further manage staff costs is, however, somewhat limited by decisions taken by Member States at the UN-wide level.

- **Travel.** Measures introduced in 2016 are expected to show a 10% reduction in travel cost compared to 2015, and new travel policies are being implemented with effect from January 2017, to further increase controls over meeting and other travel costs.

- **Insurance.** Over the last 18 months WHO has completed an in-depth review of worldwide insurance arrangements, for both personnel and non-personnel insurance and risk management requirements. This includes staff and non-staff accident and liability risks, and building, vehicle and cargo risks. As a result of consolidation of risks, and re-negotiation of policies, WHO has achieved both better risk coverage and a lower overall cost.

### Monitoring and demonstrating results

67. Two key aspects of WHO’s accountability framework are monitoring progress towards achieving the outputs, as well as their contribution to achieving outcomes and impacts, and assessing the Organization’s performance. WHO monitors and reports on progress in implementation of the Programme budget through the mid-term review which is issued at the mid-point of the biennium. Overall performance towards achieving results and use of strategically allocated resources will be assessed and reported on through the programme budget performance assessment at the end of the biennium. The programme budget web portal, which is regularly updated, will continue to ensure transparency,

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6 The following can be noted: (i) an increase in the number of staff in country offices, with a decrease in the number of staff in regional offices in all regions for Category 6; (ii) in the European Region, a reduction in the budget for staff by around 20% with a doubling of the budget for staff at the country level; and (iii) in the African Region, the number of regional office staff for Category 6 has been reduced, while there is an increase in the number of staff in country offices.
allowing Member States to monitor the status of financing and implementation of the programme budget.

68. More robust processes for the mid-term review and the end-of-biennium performance assessment have been established. The strengthening of monitoring and performance assessment focuses on: (i) performance measures, including outcome and output indicators and targets, together with an analysis of assumptions and risks; (ii) improved analysis of changes resulting from the Organization's work, in particular the combined influence of outputs on health outcomes, and the consequent impact on people’s lives; and (iii) clearer linkages between assessment of results and resource use.

69. For the first time, the assessment of organizational programmatic performance during the biennium has been reported jointly with the WHO's financial situation for 2014-2015. This is a logical evolution at a time of ongoing reforms at WHO and in a health development climate that places a premium on transparency, accountability and measurable results. By drawing together material previously issued in separate reports, the document lets readers see how the financial resources requested by WHO are being used to make progress in achieving planned results.

70. The indicators, with baseline and target, provide a more objective measurement of progress and performance against the results expected. Although the indicators do not cover all the results, they represent the dimension that is most relevant to the work and the expected changes. The outcome indicators are taken from existing agreements, strategies and plans. The output indicators have been discussed and agreed across the three levels of the Organization through interaction within each programme area network.

71. Greater objectivity in results monitoring is envisaged with improved harmonization and coherence with other methodologies that supplement or reinforce the current self-assessment methods. Examples of these methodologies, which provide a greater depth and degree of independence, include, joint reviews and performance assessments with Member States programme and administrative reviews, specific technical programme reviews, audits and corporate evaluations. The Secretariat will pursue the enhanced coherence and cohesiveness of those methodologies by firmly establishing the evaluation policy and evaluation framework.

**Transparency and Accountability**

72. The importance of transparency in development has rightly received much attention in recent years. Developing countries face huge challenges in accessing up-to-date information about aid, development, and humanitarian flows – information that they need to plan and manage those resources effectively. Similarly, citizens in developing countries and in donor countries lack the information they need to hold their governments accountable for the use of those resources.
73. At WHO, transparency has been a priority area of reform for some time and significant progress has been made in response to growing interest in this area from the international community. WHO aims to make key information about its spending easier to access, use, and understand.

74. The Programme Budget Web Portal was launched in 2013 in response to Member State calls for increased transparency of WHO financing and improved reporting on results. WHO's web portal, a pioneering tool within the UN system, comprises: (i) a transparent view of WHO's programme budget, baseline and targets for results, and key deliverables for each level of WHO; (ii) detailed information on WHO's budget structure, across programmes area, major offices and countries, including staff and activity resource requirements; (iii) financing information on available and projected funds and remaining funding shortfalls, and funding flows by donors to programmes and countries. The date of the Web Portal are updated quarterly and its functionalities regularly enhanced with more details.

75. In November 2015, the Director-General announced WHO's commitment to join the International Aid Transparency Initiative (IATI), a voluntary, multi-stakeholder initiative that seeks to increase the transparency of development cooperation and increase its effectiveness in tackling poverty. WHO has now formally joined the Initiative as of 1 November 2016, and the first submission of information for publication on the International Aid Transparency Initiative platform is due at the end of the first quarter of 2017. The same information will also be available through the Web Portal.

76. Furthermore, WHO is formulating an information disclosure policy, based on best practice in the United Nations system, with implementation planned for early 2017.

77. Strengthened Organizational accountability continues to remain a priority area of reform. Annual accountability compacts between the Director-General and senior management in headquarters are now published on the WHO website and include leadership, stewardship and behavioural objectives that are monitored and discussed on a quarterly basis. Delegations of Authority and Letters of Representation of Regional Directors have also been published for the first time.

78. Particular emphasis is being placed on accountability in country offices: self-assessment checklists have been rolled out there, while development of key performance indicators is ongoing. The European Region, for instance, has implemented an initiative to clearly define in a matrix who is responsible, accountable, consulted and informed, for the different steps of the main business processes down to country level. The African Region has defined key managerial performance indicators for a variety of areas (such as finance, procurement, travel and security), establishing measurable targets and respective data sources for all country offices. Ranges of target achievement have been agreed on and will be used during the performance appraisal of the relevant staff in country offices.

79. Steps to encourage adherence to core ethical values and standards of conduct, to bring to the attention of staff that wrongdoings have consequences, have included the publication of an annual report on investigations and an annual update to staff on disciplinary measures taken in response to cases of misconduct. During the period early-2012 to early-2016, 41 disciplinary actions were taken. A policy on whistle-blowing and protection against retaliation has been operationalized, with the introduction of an “integrity hotline” in June 2016, which makes available free telephone numbers and a web access tool in all WHO locations for the reporting of alleged misconduct to an independent external party which reports back to the Secretariat.
80. In response to weaknesses identified in the audit of direct financial cooperation that was conducted in 2014, several procedural improvements have been implemented over the past two years to ensure the correct use of funds. As a result, 27 of 33 audit recommendations have been fully implemented, relating to improved policies, processes and controls for direct financial cooperation. The remaining six are in progress and relate mainly to providing further evidence of how assurance activities are being carried out in practice and the consequences of assurance findings. Notably, efforts to enhance accountability in recent years have materialized in a reduction of outstanding audit recommendations from 25% in 2010 to 3% in 2016.

81. The corporate risk-management policy entered into force in November 2015, and the first full risk-management cycle was completed in June 2016 with reports submitted to senior management and the introduction of the concept of "critical risks" – those risks scored as significant and severe and for which senior management was requested to take a final decision on the risk response actions and to ensure that those actions were implemented. All budget centres in WHO have established risk registers, with dedicated risk mitigation plans in place for 98% of all identified risks across the Organization. The Secretariat is creating a web-based register of risks to which Member States will have access.

82. WHO's strengthened accountability initiatives have manifested in significant improvements risk management, integrated performance assessment and financial reporting, and strengthened internal financial controls through an organization wide internal control framework supported by real-time management dashboards to monitor progress on key administrative and managerial metrics.