



**World Health
Organization**

**EXECUTIVE BOARD
134th session
Provisional agenda item 11.1**

**EB134/39
3 January 2014**

Evaluation

Second stage evaluation on WHO reform

In line with decisions EBSS2(3) and EB132(14), the Director-General has the honour to transmit to the 134th session of the Executive Board the report of the second stage evaluation on WHO reform (see Annex), prepared by an external consultant.

ANNEX

***WHO Reform
Stage 2
Evaluation***
Final Report

18 November 2013

*PricewaterhouseCoopers SA
Avenue Giuseppe-Motta 50
P.O Box 2895
1211 Geneva 2
Phone +41 58 792 91 00
Fax +41 58 792 91 10
www.pwc.ch*

**Office 7121
Ref: IOS Stage two
Attn: Mr David Webb, Director
Office of Internal Oversight Services
World Health Organization
20, Avenue Appia
CH-1211 Geneva 27
Switzerland**

Geneva, 18 November 2013

Dear Sir / Madam,

The Independent Evaluation Team (IET) from PwC is pleased to provide you with our report on the Stage 2 Independent Evaluation (“the evaluation”) of the World Health Organization (“WHO”) reform.

We prepared this report in accordance with our contract dated 27 June 2013 and the terms and conditions included herein. We conducted the evaluation between July and October 2013. During this time, the IET organised more than 100 structured interviews with WHO management and staff at the three levels of the Organization, selected representatives of Member States, civil society, donors and global health advisors. We complemented the interviews by attending a number of internal WHO governance meetings. We also conducted an online staff survey of close to 1’300 WHO staff and performed in-depth analysis of all information gathered. We issued a preliminary report on 28 October which the Evaluation Management Group (EMG) and Secretariat commented on. This final report reflects their feedback. The evaluation followed the United Nations Evaluation Group (UNEG) norms and standards for evaluations, as well as ethical guidelines, and reflects our independent view.

We remain at your disposal for any further information or clarification on this document and look forward to hearing from you.

Yours faithfully,

PricewaterhouseCoopers SA

Gill Sivyer
Engagement Partner

Antoine Berthaut
Engagement Director

Acknowledgments	4
Glossary	5
1. Executive Summary	7
2. Introduction	15
2.1. Background	15
2.2. Objectives of the Stage 2 Evaluation	16
2.3. Approach underpinning the evaluation	18
2.4. Structure of the report	21
3. Overall progress on the reform	23
3.1. Reform progress to date	23
3.2. Stage 1 Evaluation and JIU recommendations	27
4. Programmatic reform	39
4.1. Background	39
4.2. Status	39
5. Governance reform	47
5.1. Background	47
5.2. Status	48
6. Managerial reform	56
6.1. Background	56
6.2. Status	57
7. Programme Management	67
7.1. Background	67
7.2. Status	67
8. Change management and communication	80
8.1. Background	80
8.2. Status	80
9. Recommendations	88
9.1. Recommendation # 1: Ownership and accountability of Member States	88
9.2. Recommendation # 2: Improve benefit management through a stronger theory of change of the reform	93
9.3. Recommendation # 3: Realign change and communication activities based on a thorough organisational impact assessment	96
9.4. Recommendation # 4: Strengthen reform Programme Management	100

Acknowledgments

The independent evaluation team (IET) of PwC values and appreciates the contributions from WHO staff, Member States, NGOs, donors and global health stakeholders, and their availability for consultation. We also wish to thank the Evaluation Management Group (EMG), the office of Internal Oversight Services (IOS) and the Reform Support Team (RST) for their guidance and assistance throughout the evaluation.

Glossary

AC	Assessed contributions
ADG	Assistant Director General
AMR	WHO Americas region
AMRO	WHO Regional Office for the Americas
AFR	WHO African region
AFRO	World Health Organization Africa Region
ASEAN	Association of Southeast Asian Nations
BO	Business Owners of the reform
CCU	Country Coordination and United Nations Collaboration
CCS	Country Cooperation Strategy
DDG	Deputy Director General
DG	Director- General
DAF	Director of Administration and Finance
DFID	Department for International Development UK
DPM	Director of Programme Management
EB	Executive Board
EMG	Evaluation Management Group
EMR	WHO Eastern Mediterranean region
EMRO	WHO Regional Office for the Eastern Mediterranean
EUR	WHO European region
EURO	WHO Regional Office for Europe
ERM	Enterprise risk management
FNM	Department of Finance
GBS	Department of Governing Bodies and External Relations
GNE	Global network on evaluation
GMG	General Management Cluster
GPG	Global Policy Group
GPMT+	Global Polio Management Team Plus
GPW	General Programme of Work (WHO)
GSC	Global Service Center
GSM	Global Management System
HLIP	High-level implementation plan
HR	Human Resources
HRD	Department of Human Resources Management (WHO HQ)
HRH	Human Resources for Health
HQ	Headquarters
IET	Independent evaluation team
IEOAC	Independent expert oversight advisory committee
IHP+	The International Health Partnership
IHR	International health regulations
JIU	Joint Inspection Unit of the United Nations System
KPI	Key performance indicators
IOS	Internal Oversight Services
IP	International Professional
MDG	Millennium Development Goals

MoH	Ministry of Health
NCDs	Noncommunicable diseases
NGO	Non-governmental organisation
NPO	National Professional Officer
PAHO	Pan American Health Organization
PASB	Pan American Sanitary Bureau
PB	Programme Budget (WHO)
PBAC	Programme, Budget and Administration Committee of the Executive Board
PEPFAR	President's Emergency Plan for AIDS Relief
PMDS	Performance management and development system
PRP	Planning Resource Coordination and Performance Monitoring
RBM	Results Based Management
RC	Regional committee
RD	Regional director
RfP	Request for proposal
RO	Regional office
RST	Reform Support Team
SEAR	WHO South-East Asia region
SEARO	WHO Regional Office for South-East Asia
ToR	Terms of reference
UNASUR	Union of South American Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDG	United Nations Development Group
UNDP	United Nations Development Programme
UNEG	United Nations Evaluation Group
UNICEF	United Nations Children's Fund
VC	Voluntary contributions
WHA	World Health Assembly
WHO	World Health Organization
WPR	WHO Western Pacific region
WPRO	WHO Regional Office for the Western Pacific
WR	WHO Representative

1. Executive Summary

Background

The WHO Executive Board at its special session on reform in November 2011 requested a two stage evaluation of the WHO reform. The **first stage of the evaluation** was presented to the Executive Board (EB) in May 2012 and focused on whether the WHO reform proposals had identified an appropriate range of issues that needed to be dealt with in the reform process and made recommendations on the roadmap for the **second stage of the evaluation**. Those recommendations, and the JIU review of management, administration and decentralization at WHO (2012), have informed the work of the Secretariat concerning the coherence between, and functioning of, the three levels of the Organization. The objective of the second stage of the evaluation is to assess the WHO reform implementation strategy and the Organization's preparedness to implement the reform process. In particular, this stage of the evaluation is designed to assess whether change management issues and barriers to implementation have been appropriately considered and addressed.

The terms of reference for the second stage of the evaluation, approved by the Executive Board at its 132nd session in January 2013 contain the following scope of assessment:

- (i) Status of action taken on the recommendations of stage one.
- (ii) Modalities of implementing the reform proposal and the sufficiency of the change management strategy including:
 - Prioritization of various components of the reform proposal
 - Identification of change agents
 - Capability of accountability structures to support the reform process
 - Resource requirements for the reform proposal
 - Timelines defined for the implementation of the reform proposal
 - Performance indicators defined to measure movement towards reform process
 - Strategy to deal with hindrances, enablers and dependencies
 - Changes in internal procedures and structures to implement the reform process

An Evaluation Management Group (EMG) comprising representatives from the Executive Board and a representative of the Joint Inspection Unit (JIU) reviewed the progress and provided guidance throughout the performance of the evaluation.

Following a competitive bidding process, an Independent Evaluation Team (IET) from PwC was selected to carry out the Stage 2 evaluation.

In order to deliver on the above objectives, we adopted a structured and systematic approach, underpinned by a conceptual framework that built on best practices for transformation programmes. First, in a '**Mobilise**' **Phase** we refined further the above scope in an inception report endorsed by the EMG. Second, in an '**Evaluate**' **Phase** we carried out a detailed analysis through a desk review; an online survey of more than 1300 staff; observation of key meetings; and more than 100 interviews with Secretariat staff and management, selected representatives of Members States, and external stakeholders. We organised specific meetings with the Secretariat in order to validate findings, to collect feedback and to present our results. Third, in a '**Synthesize and Report**' **Phase** we documented findings and recommendations in a preliminary report which was reviewed by the EMG. The Secretariat also had an opportunity to provide feedback on factual accuracy. This final report takes into account the feedback received.

This executive summary highlights the key findings arising from the evaluation together with the recognition of achievements to date, and recommendations to overcome the challenges we have identified.

Assessment of the WHO reform status and implementation of Stage 1 recommendations

Since the completion of the stage 1 evaluation, a number of reform initiatives have progressed and have taken into account the recommendations made by the external auditor of the WHO.

Some of the most notable and tangible achievements to date include:

- **Programmatic priority-setting reform:** Member States agreed new criteria for prioritising WHO's programmes and a new results-chain as the basis for the 12th General Programme of Work (GPW) 2014-19 and Programme Budget (PB) 2014-15. The GPW was approved unanimously by Member States, a powerful signal demonstrating the willingness of Member States to achieve consensus on major strategic items. For the first time the PB 2014-15 was approved in its entirety. These achievements set a clear direction for the work of the Organization moving forward.
- **Governance reform:** Member States endorsed structural changes to the terms of reference of the Programme Budget and Administration Committee (PBAC) and to the reporting mechanisms between regional and global governing bodies; and harmonised rules for the nomination process for Regional Directors, the review of credentials of Member States delegates, and the participation of non- Member States observers in Regional Committees (RCs). These changes in internal governance arrangements are tangible evidence of a more coordinated approach to how the Organization works. Member States are in the process of adapting to operate within this framework.
- **Managerial reform:** The Financing Dialogue and its web-portal are in a pilot phase and as part of this, the Secretariat has led consultations to broaden the donor base. The capacity of the communication function has been strengthened. The World Health Assembly endorsed a new evaluation policy in May 2012. Progress has been made by the Secretariat in developing internal control and risk management frameworks, making revised standard operating procedures available as an e-booklet, and rolling-out a management dashboard. WHO Representatives (WR) have been attending a well-received training on 'Global Health Diplomacy' to address the growing needs of Member States in this area.
- **Reform change management:** the Secretariat designed and implemented a delivery model for the reform with the support of a dedicated central Reform Support Team (RST) located in the Director-General's Office (DGO). This team produced a High Level Implementation Plan and monitoring framework (HLIP) for the reform and some communication activities are taking place that have given visibility to the reform process (i.e. website and WHO reform story). Improvements on planning, monitoring and risk management of the reform are also underway.

With four areas, 13 initiatives, 51 outputs and 143 deliverables however, the WHO's reform is an ambitious, transformative and complex endeavour. Initiatives are moving at different speeds and the whole reform will take time to get to full completion.

Based on our analysis, at the time of writing this report, 33% of reform outputs have reached the implementation stage (17 out of 51). As a consequence and despite all stage 1 recommendations being taken into account in the HLIP, out of those 13 recommendations, 5 have been completed or partially completed, 7 are still in progress and 1 has yet to be initiated. Similarly out of 21 reform related recommendations made by the Joint Inspection Unit (JIU) in 2012, 6 have been completed or partially completed, 9 are in progress and 6 have yet to

be initiated. This illustrates the **results which have been achieved but also the significant work that lies ahead of the Secretariat and Member States.**

Among the major challenges ahead we note:

- The GPW priority-setting exercise was a good step in the right direction, but **more work needs to be done to align Member States expectations and decision making in such a way that the increased focus on WHO activities actually happens.** The number and variety of activities that WHO sets out to deliver remains broad, and with what we consider a constrained budget, it will prove challenging for WHO to demonstrate impact against the priorities set out in the 12th GPW and to deliver on its core mandate.
- **Slow progress has been made on coordinating resource mobilisation efforts across the three levels of the organisation:** only 19% of respondents to the staff survey agreed or strongly agreed that there is adequate coordination in resource mobilisation activities across the organisation. Only 23% agreed or strongly agreed that they conduct resource mobilisation activities (if any) as part of a coordinated approach across the whole of WHO.
- **The Secretariat’s operating model, including concrete shifts in staffing, service delivery and skillsets, has yet to be reformed** for the Secretariat to be in a position to deliver against its expectations. WHO offices vary widely in size and capacity, but only rarely in relation to a country’s actual needs. A more robust articulation of how WHO will set out to deliver on GPW objectives, notably the alignment of country offices with country’s needs, the definition of mechanisms for coordination across the levels and geographies of the Organization, and a better definition of WHO’s strategic approach to partnering with stakeholders will position the Organization for greater effectiveness.
- **WHO has yet to resolve the intrinsic tension between the sovereign right of Member States to pursue their national priorities and the need to have a realistic number of agenda items at governing bodies.** The ultimate result is, however, detrimental to all, including to those Member States exercising their sovereignty. This leads to a lack of adequate time to prepare for governing body meetings. In turn, strategic items are not being discussed in sufficient depth, and decisions are postponed.
- **WHO is making marginal progress in improving its focus on strategic decision-making and addressing the goal of greater coherence in global health.** There are indications that despite revised internal governance arrangements, the Organization needs to do more to efficiently handle governing body meetings and to be more strategic in decision making. Overall the question of how the Organization opens up to the outside world and what should be the right balance between its norm-setting and technical support role in global health has yet to be effectively addressed.
- **The Organization has had to date a rather piecemeal approach to the reform of HR management and currently lacks an effective people vision that would be attractive to talent,** at a time when WHO needs to remain attractive to the best technical specialists.
- **The strengthening of results-orientation, accountability, internal controls and risk management throughout the Organization represents a major cultural shift which will require significant behavioural change at all levels of the organisation.** To achieve this, the Secretariat will need to go beyond the current focus on policies, procedures and systems.

Against this background, the Secretariat will need to manage the expectations of Member States to demonstrate progress whilst also ensuring that drive and momentum are maintained in a sustainable way and that benefits are accrued along the way. Further change will place a considerable time burden and impact on WHO staff, management and Member States. As a number of initiatives will enter into implementation state concurrently in 2014, tight coordination and alignment from the Secretariat will therefore be paramount.

Assessment of programme and change management of the reform

Given the above, effective programme and change management will be key to accelerate the delivery of benefits, to increase the sustainability of changes, and to make the reform a success.

A number of building blocks for programme and change management are in place, starting with a clear and demonstrated commitment to reform from WHO elected leadership at the global and regional level. Reform roles have been distributed across the Organization. The reform package has been shaped into a comprehensive and structured set of initiatives endorsed by the Secretariat and Member States and is reflected in the HLIP. Budget and financial resources have been allocated. After an initial successful focus on Member States, communication efforts are now being redeployed to address staff at all levels of the Organization. Overall, WHO has managed to build momentum around the reform, has demonstrated some initial results and is showing drive to execute against the implementation plan.

It is, however, fair to say that the approach has to an extent been rather ad-hoc, the drive of the RST not completely making up for the lack of experienced programme and change management skills. As programme management activities progressively mature, the RST is revisiting its approach and implementing more stringent programme and change management discipline. Improvements underway relate notably to the implementation of a programme management tool to allow easier tracking and reporting of the various reform projects and initiatives. A rework of the theory of change on reform is also in progress in order to strengthen it. The RST also presented an initial draft of a risk management framework for the reform at the October 2013 meeting of the Independent expert oversight advisory committee (IEOAC) for feedback. This demonstrates willingness and responsiveness of the RST to make improvements to their programme management practices.

Although a number of stakeholders, most notably donors, have pointed out to the need for fast results, we obtained widespread feedback from **Member States, management and staff alike that the pace at which reform is being executed would either require many more resources, predictable planning and focus on change management activities, than is currently deployed, or would need to be revisited to ensure those Member States and staff stay on the journey.** With 17 initiatives in implementation concurrently, and 5 more planned in 2014 now is the right time to shift programme and change management to a more systematic and organisation-wide approach.

The most pressing elements to be addressed in the short term relate to:

- With the exception of a dedicated RST and identified reform Business Owners, most reform activities are governed through existing roles, structures and committees. Whilst alternative and dedicated structures could have been envisaged, we see this as a strength in the sense that it ensures that reform is at the heart of how WHO conducts its daily business. The current approach does, however, require **a number of adaptations to ensure those roles and structures are fit for reform purpose**, that monitoring and reporting on reform progress, resource utilisation, benefit realisation and risks takes place, and that the execution of initiatives is conducive to an effective reform. **Most notably the effectiveness of the Global Policy Group (GPG) in ensuring the coherence of reform activities at global and regional level can be improved; support and coordination to Business Owners can be improved; and the engagement of technical Directors and WRs should be strengthened.**

- **The robustness of the reform results-chain, theory of change and monitoring framework needs to be strengthened.** Most notably outcome indicators are weak. This limits the ability of the Secretariat to first, direct efforts to areas that are most closely linked to the achievement of reform outcomes and second, report on the benefit realisation of the reform. Further outputs and deliverables are mostly of an ‘Assess and Strategise’ and ‘Design’ nature (33% and 51% respectively) and with only 3 out of 151 deliverables relating to training. Since the status of implementation and institutionalisation of deliverables is not tracked, the reporting on the completion of outputs can give a false sense of comfort that reform is more advanced than it actually is.
- **Project management discipline needs to be implemented ‘as a way of doing reform’, rather than as a one-off or ad-hoc undertaking.** Improved management should start with detailed, realistic and comprehensive planning and budgeting by reform Business Owners relating to the necessary financial and human resources. There is a strong need to improve the management of risks and dependencies as an integral part of reform programme management. Such an approach will require to differentiate the reporting of risk management activities by the Secretariat, and the identification and discussion of governance risks that require active involvement from Member States. The reporting on progress of activities, realisation of expected benefits, mitigation of risks and resource utilisation needs to **move from being event driven** (e.g. PBAC presentation) **to a monthly process supporting management and reform execution.**
- **The change, communication and risk management activities need to be informed by a thorough assessment of the organisational impact of reform on various stakeholder groups.** The results from the staff survey on reform and interviews carried out with staff and management show that there is some way to go to ensure communication moves from a broadcast and information mode to one where information is tailored to recipients’ needs, and where proper engagement with staff takes place. The Organization has yet to fully engage and secure the support of the 250 change agents who will play a determining role in implementing and institutionalising reform across the Organization.

In many ways, the above is illustrative of the paradox of such an ambitious reform. The culture that WHO is seeking to implement through reform is one that is results-oriented, takes into account transversal ways of working across organisational silos, and adheres to a risk management mindset. It is this culture, however, which is needed in the first place to drive the implementation of the reform successfully.

Relying on legacy ways of working to implement new ones inevitably carries material risks. We believe, however, that these risks are for the most part manageable; and that they have to be compared to the risk of not implementing the reform. The latter would have understandably more negative consequences on the future prospects for the Organization and for global health.

Recommendations

Based on the findings of the evaluation, we have defined four overarching recommendations, further broken down into 46 supporting actions.

Recommendation # 1: Ownership and accountability of Member States relates to Member States playing an active role in the success of the reform. Whilst most of the ‘heavy lifting’ on reform rests with the Secretariat, Members States’ role in effecting the reform can be highlighted in three areas:

- **Fulfilling their duty of care for the Organization, notably through adequate financing.** Options available to Member States are increasing assessed contributions, extending the pool of voluntary donors and committing and enforcing a policy with their various departments (notably the Ministries of Health and of Foreign Affairs) that the standard Programme Support Charge (PSC) rate is not for negotiation in grant discussions with WHO, and that the PSC should be funded.

- **Making the governance reform successful through a shift to more strategic decision making.** This will involve Member States and the Secretariat working together to achieve a manageable number of items and an adequate degree of preparation for governing body meetings together with proper handling of meetings and discussions. The recommendations of the IET relate to reinforcing the training, support to and role of committee chairs in order to effect proper division of labour and coordination between committees. Our recommendations also emphasise the need to strive for more discipline during Member States interventions and to monitor behaviour and contribution at governing body meetings.
- **Organising themselves to provide efficient and effective oversight over the reform,** by defining how governance risks contained in the reform risk register will be communicated to Member States, managing efficiently the material number of items in governing body meeting relating to reform and strengthening the role of the IEOAC in the oversight of reform risks and finances.

Recommendation # 2: Improving benefit management through a stronger theory of change for the reform relates to the strengthening of the HLIP and reform monitoring framework in such a way that they can better fulfil their purpose as management and accountability tools. The starting point for strengthening the HLIP can be the existing principles of using a theory of change and results-chain, complemented by some of the concepts on stages of transformation used in this evaluation. Focus should notably be on ensuring that outputs and deliverables consider the whole lifecycle of change and that thorough work is done on key performance indicators, notably through defining specific impact indicators demonstrating the benefit of the reform. On this basis, the scheduling and progressive benefit realisation of reform initiatives should be articulated and reprioritised. Such a shift would enable the leadership to maintain momentum and to hold the Organization accountable for progress towards outcomes and impact. In order to achieve this, additional training of relevant staff on theory of change may be required. This recommendation is primarily targeted at the RST and GPG, and should be endorsed by Member States.

Recommendation # 3: Realigning change and communication activities based on a thorough organisational impact assessment to address change management needs. First, it starts with performing a thorough assessment of the desired and negative concrete impacts reform initiatives will have on various stakeholder groups. Second, based on this impact assessment the various change and communication interventions should be identified by the RST, in collaboration with BOs, Directors of Programme Management (DPM), Directors of Administration and Finance (DAF) and WHO country representatives. This will allow management to give change and communication management activities a clearer purpose. Given the importance of Technical Directors and WRs in the upcoming phases of implementation and their limited engagement with reform to date, increased focus should be given to building their skills. Finally, in order to mitigate some governance risks, innovative approaches to assist Member States in the adaptation of their individual and collective behaviours should be considered (e.g. strengthening the change agent network for Member States or leveraging independent and trusted voices, such as those from retired experienced EB or RC members). This recommendation is primarily targeted at the RST and Business Owners.

Recommendation # 4: Strengthening reform Programme Management consists in building capacity in programme and project management in the RST and across the Organization, through adequate staffing and training. Only then can programme management practices be implemented in a reliable, continuous and risk-managed way. Specific emphasis should be placed on planning and budgeting for reform activities, enhancing internal reform management structures, and moving from an event driven approach to **reporting to a monthly reporting process**. This recommendation is primarily targeted at the RST. A specific recommendation relating to institutionalising quality assurance and evaluation mechanisms on reform should be discussed by the Executive Board.

The table below lists the recommendations, their suggested timeframe for implementation and owner.

Recommendation and actions	Timeframe	Responsibility
Recommendation 1. Ownership and accountability of Member States		
Financial responsibility and duty of care		
1. Consider increasing Assessed Contributions	From 2016	Member States
2. Extend the donor base	2014-2017	PRP
3. Ensure coherence between Member States as AC contributor and Member States as a donor	From 2014	Member States
Shifting to strategic decision-making		
4. Ensure adequate definition of skills, training and support requirement for committee chairs	End 2014	GBS
5. Set-up a formal process to ensure regular communication between the chairs of EB, PBAC and RCs is strengthened prior to and after governing body meetings	End 2014	GBS
6. Ensure that chairs and bureaus are empowered to define a manageable agenda for meetings – set targets on the evolution of the number of agenda items	End 2014	GBS to support Member States
7. Strive for more discipline during Member States interventions and monitor general behaviour at governing body meetings	End 2014	Committee chairs
8. Ensure adequate consultations on proposals for the management of agenda items, resolutions and the running of governing body meetings prior to formal meetings	End 2014	GBS
Organising for proper oversight of reform activities		
9. Make proposals to the Executive Board on how these risks will be concretely reported to Member States and discussed, notably in terms of defining and executing mitigation strategies and accepting residual risks	May 2014	RST
10. Consider alternatives such as 1) Being more selective on the agenda items relating to reform that are presented at PBAC and EB; 2) Organising special sessions of the PBAC focusing solely on reform, or 3) Extending the duration of PBAC meetings	From May 2014	EB and PBAC
11. Consider 1) reviewing regularly the reform risk register to identify areas where better risk management and more efficient risk mitigating activities can be developed; 2) Requesting detailed financial data from the RST to allow it to perform a thorough review of the reform budget utilisation and advising on ways forward; 3) providing in annual reports to the PBAC, detailed evidence-based analysis and clear guidance to the PBAC on how to address reform-related risks	From May 2014	IEOAC
12. Develop a reform induction pack for new IEOAC members	January 2014	RST
Recommendation 2. Improve benefit management through a stronger theory of change of the reform		
Strengthen the results-chain for the reform		
13. Present a strengthened theory of change for the reform to governing bodies ensuring 1) that outputs and deliverables consider the whole lifecycle of change and 2) robust key performance indicators are defined that demonstrate the benefit of the reform	May 2014	RST
Reprioritise areas of focus		
14. Refine priorities and areas of focus based on expected results, and present to governing bodies	May 2014	RST
Recommendation 3. Realign change and communication activities based on a thorough organisational impact assessment		
Conduct an organisational impact assessment		
15. Identify the stakeholders impacted by each reform initiative and by the overall reform process underway	March 2014	RST, with BOs
16. Organise workshops with Business Owners and their networks to document those impacts. Consolidate the results into an impact assessment.	March 2014	RST
Realign communication and change management plans		
17. Refine change and communication interventions based on impact assessment	May 2014	RST with BOs, DPM, DAFs and WRs.
18. Develop and update regularly talking points for managers and supervisors on the specific initiatives	March 2014	Business Owners
19. Organise regular briefing sessions for supervisors	March 2014	RST, DPMs, DAFs and WRs
Focus on WRs		
20. Equip WRs with key messages and talking points to be delivered to their respective Ministries of Health and external partners on the WHO reform	March 2014	DPMs with BOs

Recommendation and actions	Timeframe	Responsibility
21. Ensure regular and detailed briefing of WRs on the status, relevance and expected impact of reform on country offices.	April 2014	RDs
22. Empower WRs to support Member States in to adapting their individual and collective behaviours during governing body meetings	End 2014	RDs
23. Create a space and platform for inter-regional discussions among WRs	January 2014	ROs
Focus on Directors		
24. Involve technical Directors in the concrete operationalisation of the PB 2014-15. Plan and organise their involvement in the operational planning process for 2016-17	January 2014	GMG
25. Appoint technical Directors in taskforces in general and ensure their full contribution	January 2014	DG
26. Define accountability frameworks to implement the reform, where technical Directors are directly made responsible for concrete activities	May 2014	GPG
27. Reform communication to provide specific material on reform to ADGs, DPMs and technical directors	May 2014	RST
28. Consider ensuring that in each cluster and Regional Office at least one “Go To” Director is appointed that plays a role in providing information	May 2014	ADGs, RDs with support of RST
Explore Innovative options to facilitate Member States individual and collective behavioural shifts		
29. Conduct a stakeholders mapping of Member States opinions and interests for each reform initiative	January 2014	RST with GBS
30. Ensure proactive efforts in securing support addressing Member States concerns in advance of governing body meetings	December 2014	GBS and ROs
Recommendation 4. Strengthen reform Programme Management		
Reinforce PM capacity of the Reform Support Team and BOs		
31. Provide programme and project management training to the Reform Support Team, Business Owners or their supporting staff	September 2014	RST
32. Appoint a senior programme manager to reinforce the RST	February 2014	RST
33. Consider on-boarding additional project managers to drive specific reform initiatives	From February 2014	BOs, DAFs, DPMs
Re-engineer planning and budgeting processes		
34. Refine the action plans underpinning each output and outcome	May 2014	BOs with support of RST, DPMs and DAFs
35. Define comprehensive and realistic budgets and operational plans defined for the 2014-15 period for consideration by Member States	May 2014	
36. Validate the relevance, pragmatism and comprehensiveness of the plans and present to Member States	May 2014	RST
37. Ensure continuous and efficient monitoring of reform budget expenditure	May 2014	RST with support from FNM
Fine tune reform management structures		
38. Strengthen the effectiveness of the GPG	January 2014	DGO
39. Improve the articulation between the GPG and ADG groups	January 2014	DG
40. Organise a dedicated quarterly or bi-annual meeting for all BOs and RST.	January 2014	RST
41. Leverage the DPM and DAF networks to organise, plan and roll-out reform implementation at regional and country level	January 2014	RST and BOs
Institute quality assurance and evaluation mechanisms on reform		
42. Perform a yearly independent evaluation of reform or as an alternative to implement a continuous quality assurance process	Yearly or bi-annually	GPG
43. Organise summative evaluations at the end of each biennium to review reform results at impact and outcome level	Late 2015	IOS, EB to agree on ToRs
44. Articulate clearly those areas where the IEOAC can add value in oversight of reform activities, e.g. in monitoring the reform risk management and financials	January 2014	PBAC
45. Ensure specific, relevant and timely input and reports are provided to the IEOAC	May 2014	RST
Implement ongoing reporting		
46. Implement tailored monthly reporting on reform	May 2014	RST, with BOs, ROs, WRs

The above recommendations if implemented in a comprehensive manner will mitigate most of the barriers to change identified in the evaluation. Additional recommendations relating to specific reform initiatives can be found in the body of the report.

2. Introduction

2.1. Background

This evaluation is one element of a far reaching reform agenda initiated by the WHO in 2010. The aim of the reform is to improve the overall performance and accountability system of the organisation to address better the changing public health needs of the world's population going forward into the 21st century.

One of the major reasons for kick starting the process of reform has been the continued unpredictability of funding and the difficulty WHO has had to secure financing for its priority activities and programmes. Additionally, and as highlighted by the report 'Review of management, administration and decentralisation in the WHO of the Joint Inspection Unit' (January 2013), WHO has been slow to reform in the areas of internal and external governance, organisational effectiveness and transparency.

Some of the main challenges identified were around the:

- Lack of predictable and flexible funding and associated challenges with priority setting
- Need for better internal governance and alignment between global and regional bodies
- Difficulty of allocating resources across various layers of governance structures
- Weak resource mobilisation capacity at all levels of the organisation
- Rise in administrative and management costs
- Rise of other global health actors and the role of the WHO in a changing environment

Starting with discussions on the future financing of WHO, an extensive consultation process was initiated in 2010-11. The resulting reform initiatives were consolidated into the *high-level implementation plan of the WHO reform*, referred to as the HLIP in this report organised around four reform areas (programmatic, governance, managerial and change management), associated outcomes and related outputs. This reform package has been validated by Member States and agreed upon as the direction for the reform.

As part of the above, the Executive Board (EB) at its special session in November 2011 requested a two stage independent evaluation of the WHO reform.

The stage 1 evaluation of the reform was conducted by WHO's then external auditors, the Comptroller and Auditor General of India, between February and March 2012, with the aim of validating the completeness, comprehensiveness and adequacy of WHO's reform proposals centred around governance, management and programmatic reform.

The recommendations made by the stage 1 evaluation included:

- Strengthening linkages between governing bodies at the regional and HQ level for greater organisational coherence.
- Strengthening the accountability systems throughout all three levels of the organisation (i.e. HQ, regional and country level) which could be supported by a more robust results-based and performance management system.
- Focusing on change management through the development of a communication strategy on reform that clearly identifies the champions of the reform at WHO.
- Implementing a sound monitoring and evaluation framework that accompanies the reform and is supported by clearly defined outcomes and outputs indicators.

The scope for the stage 2 of the evaluation was endorsed by the Executive Board at its 132nd session in January 2013 to assess the readiness of the WHO to fully implement the reform agenda and to identify the necessary conditions for success.

2.2. Objectives of the Stage 2 Evaluation

This independent evaluation has at its core the objective of supporting the reform process and assisting the WHO to identify the mechanisms and tools required to unlock some of the areas of the reform which have been lagging behind. Member States have demonstrated increasing confidence in the evaluation process accompanying the reform and have several expectations in relation to seeing the reform effectively implemented.

The audience for the evaluation is:

- The Executive Board, represented by the EMG. This evaluation represents an opportunity to validate current reporting to Member States and to foster trust and confidence in the reform process.
- Secretariat management and staff involved in reform activities. The evaluation has favoured exchange of knowledge between the independent evaluation team (IET) and the Secretariat and has contributed to paving the way for efficient, effective and sustainable change.

As most reform initiatives defined in the HLIP are underway and at different stages of implementation, the independent evaluation equally covers all aspects of the reform while bringing more depth into areas which the IET has identified as being critical to the success of the reform program and the WHO as a whole.

Further, as the Reform is still in its relatively early days, the stage 2 evaluation does not seek to assess the impact or outcome of the Reform.

The evaluation follows UNEG norms and standards for evaluations, as well as ethical guidelines.

2.2.1. Assess WHO reform status

The terms of reference for the evaluation, as well as discussions the IET has had with members of the WHO office of Internal Oversight Services (IOS), the Reform Support Team (RST) responsible for overseeing and reporting on the execution of the reform agenda, and a limited number of Member States, indicate a preference for a recommendation-oriented evaluation that addresses the following objectives:

- *Assess progress made to date on the WHO reform implementation:* the evaluation assesses the status of the reform agenda and involved reviewing and confirming progress made to date on outcomes, outputs and deliverables defined in the HLIP.
- *Assess the status of actions taken on the stage 1 recommendations:* in this context the evaluation in the first place assesses whether the recommendations mentioned in Section 2.1 above made in the context of the stage 1 evaluation have been implemented or are integrated as part of the HLIP.
- *Assess the completeness of the WHO reform Implementation plan:* Stage 1 of the evaluation validated whether the overall objectives of the reform agenda were in line with the challenges that the WHO needed to address. In contrast, stage 2 focuses on validating whether the implementation strategy supporting these initiatives addresses all required elements needed to effect change and achieve the intended results. A specific focus relates to assessing whether the theory of change or result-chain of the reform is robust and adequately translated into reform operational plans. This comes down to validating the completeness of the HLIP.

2.2.2. Assess the modalities of implementing the reform proposal and the sufficiency of the change management strategy

The second objective of the evaluation relates to validating whether the **enabling conditions** for success of the reform are met in order for the reform in general and each initiative in particular to succeed. This includes:

- Prioritisation of various components of the reform proposal
- Identification of change agents
- Capability of accountability structures to support the reform process
- Resource requirements for the reform proposal
- Timelines defined for the implementation of the reform proposal
- Performance indicators defined to measure movement towards reform process
- Strategy to deal with hindrances, enablers and dependencies
- Changes in internal procedures and structures to implement the reform process.

2.3. Approach underpinning the evaluation

2.3.1. Conceptual framework

The analytical framework used for the evaluation builds on best practices for transformation programmes. It provides a logical and systematic framework to cover the full scope of the practical challenges in shifting an organisation away from addressing incremental change to implementing lasting transformation.

Transformational change occurs when there is a fundamental shift in strategy resulting in significant changes in the way that an organisation operates, is structured or sets out to satisfy its stakeholders. Transformational change is deep and pervasive, affecting the interplay of strategy, process, people, technology and structure often requiring changes in culture (mind-set and organisational behaviour). This is the essence of WHO’s reform.

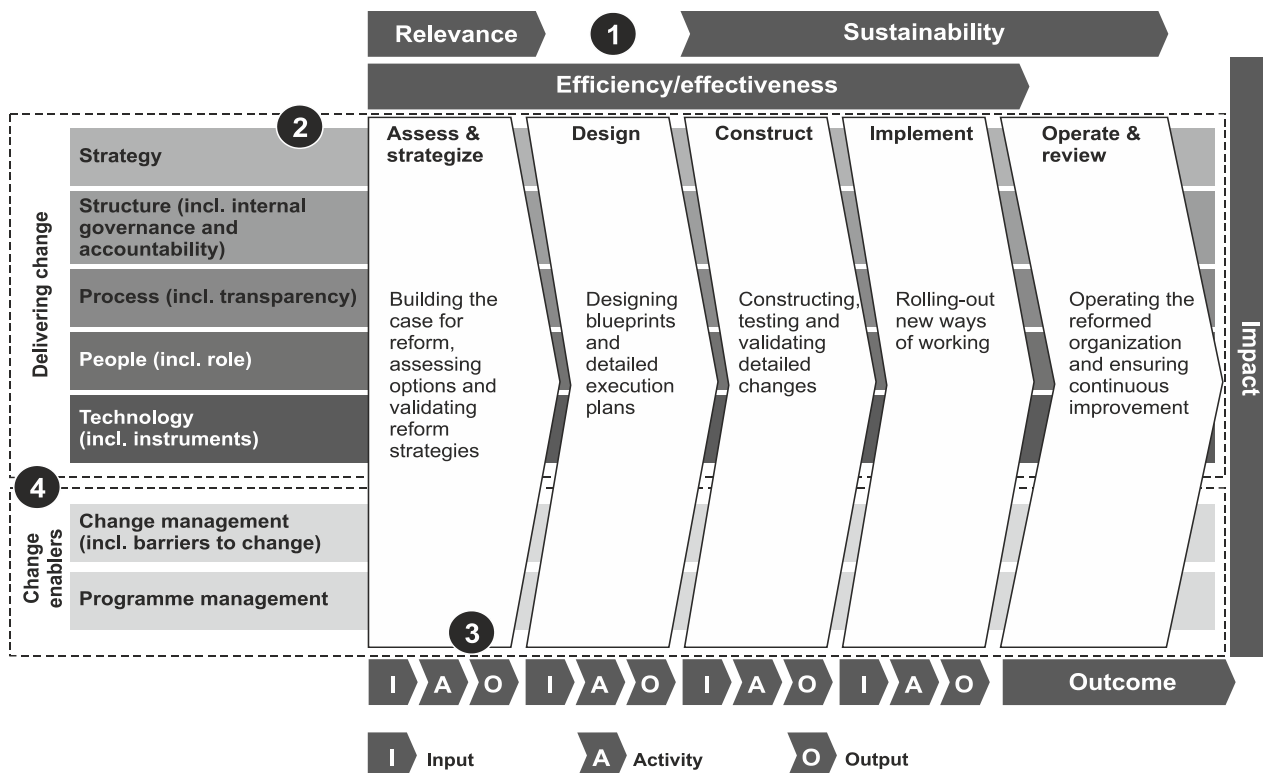
Change is often both misunderstood and also underestimated by organisational leaders because capturing its benefits requires insight into how this change impacts almost every other part of the enterprise, from strategy and structure to people, process and technology. At its heart, change is about people. It is about values and culture, the “softer elements” that many leaders find so hard to address.

The framework takes into account the following analytical elements:

- UNEG Norms and Standards for Evaluation in the UN System (referred to as 1 in **Figure 1**)
- Dimensions of a transformation programme (referred to as 2 in **Figure 1**)
- Stages of execution of a transformation programme and result-chain or theory of change to drive impact (referred to as 3 in **Figure 1**)
- Enablers for a transformation programme (referred to as 4 in **Figure 1**)

We summarise this framework in Figure 1 below which was validated with the EMG. Appendix A and B sets out greater detail on the evaluation framework, the inception report and the addendum.

Figure 1: conceptual framework for the evaluation



2.3.2. Evaluation questions

The terms of reference for the ‘Independent evaluation of the WHO reform: stage two’ propose a set of questions to be addressed by the evaluation, and which are set out in the table below. These are linked to the key issues the evaluation should address, as approved by the EB during its 132nd session¹ (EB 132/5 Add 7). The IET has supplemented those questions with a number of more detailed questions, as set out in Appendix C, which have guided the evaluation and interview process.

EB 132/5 Add 7: key issues	Proposed key questions
Status of action taken on the recommendations of stage one.	<ul style="list-style-type: none"> a) What is the status of implementation of the recommendation relating to the reform process compared with the expected (planned) progress and achievements? b) Have there been unintended effects in the reform process and how have these impacted the overall result of WHO reform? c) What factors have been identified (from progress to date) that will enhance moving forward with the reform effectively?
(ii) Modalities of implementing the reform proposal and the sufficiency of the change management strategy including:	<ul style="list-style-type: none"> d) To which degree is there coherence in the governance mechanisms to inform, monitor and evaluate the implementation of the WHO reform package? To which extent are these mechanisms and processes adequate to prioritise the various components of the reform proposal? e) What are the specific strategies to address change management? How well are the pertinent issues addressed? f) Have the significant barriers, challenges, systematic constraints, and risks for the reform been identified (including engagement of staff in the process)? How relevant and adequate are the proposed approaches for dealing with these barriers, challenges, systematic constraints, and risks in relation to achieving the outcomes expected from the reform process? How efficient are the approaches to address them to ensure sustainability? g) What is the efficacy of internal and external instruments and modalities to implement the reform proposals, including related risk management plans and risk mitigation actions? h) Are indicators and timelines sufficient, feasible and appropriate to effectively measure (monitor and evaluate) performance and report on the desired outcomes of the reform process? i) To what degree have appropriate strategies, including resource mobilisation and allocation, and corporate strategies such as human resources management and gender mainstreaming, been identified to implement the reform proposals? j) Are the necessary conditions present to ensure an appropriate level of organisational preparedness (institutional framework: structures, roles, instruments, procedures and guidelines, support systems for change process, communication, incentives)

¹ WHO, Modalities for the independent evaluation of the WHO reform: stage two, Report by the Director-General, EB132/5 Add.7, 11 January 2013.

2.3.3. Execution

The stage 2 evaluation was conducted based on a participatory approach, and in line with the conceptual framework above, the UNEG norms and standards for evaluations, as well as ethical guidelines. Throughout the evaluation, the IET had several interactions with the Evaluation Management Group (EMG), responsible for the oversight of the evaluation work; WHO senior management; the Independent expert oversight advisory committee (IEOAC); the IOS and the RST in the DGO. The evaluation comprised of three stages, described in detail below.

During a '**mobilise phase**', the IET scanned the major issues to be covered by the evaluation, through interactions with WHO senior management and a limited number of Member States who were present in Geneva for the Financing Dialogue on 24 June 2013 and available to meet informally with the IET. The product of this resulted in an inception report (and its addendum), presented in Appendix A and B, which set-out in detail the approach, instruments and detailed questions to guide the evaluation. The inception report and addendum were validated with the EMG to serve as the basis for the following phases.

An '**evaluate phase**' comprised two methodological steps corresponding to the two objectives of the review, first to assess the status of WHO reform, and second to evaluate whether conditions for success of the reform are met. During this phase, the IET:

- Undertook a total of approximately **100 interviews** face-to-face or by telephone including with around 60 WHO senior management (HQ, regional and country offices), 6 selected WHO staff, 20 Member States representatives (Ministry of Health, Ministry of Foreign Affairs and Geneva-based missions) across the 6 WHO regions, 6 NGO representatives, 1 private donor and 4 global health advisors. Refer to Appendix D for a full list of interviewees.
- Observed a number of **WHO internal meetings** including the Financing Dialogue on 24 June 2013, the Directors of Programme and Management (DPM) network meeting on 09 July 2013, a Category Network meeting on 30 July 2013, the IEOAC 10th and 11th meeting on 03 July 2013 and 16 October 2013, respectively.
- Conducted an extensive **desk review** of more than 50 reports, papers and articles relevant to the WHO reform. Refer to Appendix E for the list of documentation. Doing so, the IET has considered and built on a number of important studies issued in recent years (i.e. WHO's external auditor, Joint Inspection Unit (JIU), DFID, Chatham House) on the role and effectiveness of the WHO.
- Conducted an online and anonymous **all-staff survey** in three languages. The survey was opened for a period of 3 weeks between mid-September and 8 October 2013. A total of 1269 staff members completed the survey in its entirety, resulting in a relatively satisfactory response rate of 17.8%. This has allowed for statistically consistent analysis at the global level, with a confidence interval of 2.25 and a confidence level of 95%. The survey re-used a number of questions from the JIU 2012 survey, which act as a benchmark for the D/P/NPO (Directors, Professional staff and National Professional Officers) group. Refer to Appendix F for the survey results.

The '**synthesise and reporting**' phase consisted of consolidating the findings gathered in the previous phase, analysing and validating the data, drawing conclusions and issuing recommendations that address the main questions of the stage 2 evaluation. The reporting phase involved frequent interactions with the EMG, the IOS and the RT for the socialisation of the findings and recommendations. The present preliminary report is part of this process.

2.3.4. Limitations

This evaluation presents the following limitations:

- **Period for the evaluation.** The investigation period for the stage 2 evaluation was undertaken during the months of July, August and September 2013. Despite the willingness of stakeholders to make themselves available for interviews, not all identified stakeholders could be interviewed in this period. The period was also limited considering the scope of the evaluation.
- **Evaluation methods.** Despite our willingness to investigate outside HQ, we were limited by the fact that the scope did not consider conducting trips to the regional or country offices nor to the WHO Regional Committees scheduled in September and October 2013. Such visits and observations would have provided additional depth in the analysis, notably on the harmonisation and coordination of governance, managerial and operational practices across the Organization, and on specific programme and change management activities at regional and country level.
- **Assessment of individual reform initiatives.** Where observations and recommendations could be made on specific reform areas, they are included in the body of the report. However the scope of the evaluation is focused on identifying the patterns of barriers and enablers to reform, and not on conducting a detailed review of each reform initiative.

The findings and recommendations presented in this evaluation report should therefore be considered in light of the above limitations.

2.4. Structure of the report

We have shared and discussed our analysis with the Evaluation Management Group responsible for oversight of the evaluation and senior management at the WHO Secretariat. This has enabled us to validate findings, refine observations and gain endorsement for the findings and recommendations we present in this evaluation as follows:

- Section 2: *Introduction* presents an outline of the work performed, the evaluation approach used, the methodology and evaluation questions, assumptions and limitations.
- Section 3: *Overall Progress on Reform* provides our overview of the current status of implementation of the reform programme. This section also presents the status of implementation of the recommendations issued by the Stage 1 Evaluation of the WHO Reform and the JIU 'Review of management, administration and decentralization in the WHO'. This section addresses the RfP question (a).
- Section 4: *Programmatic Reform* looks in detail into the two major outputs of this reform area, namely the 12th General Programme of Work (GPW) 2014-19 and the Programme Budget (PB) 2014-15. This section addresses the RfP question (a), (b) and (c).
- Section 5: *Governance Reform* presents our detailed findings on the status of the governance reform. We identify the major highlights and challenges encountered in reforming WHO's internal and external governance structure. This section addresses the RfP questions (a), (b) and (c).

- Section 6: *Managerial reform* presents our detailed findings on the status of the managerial reform. We identify the major highlights and challenges encountered in improving accountability, transparency and performance at WHO. This section addresses the RfP questions (a), (b), (c) and (i).
- Section 7: *Change management* assesses the extent to which a number of change management and communication activities and techniques have been applied to accompany the reform process. We identify whether key change management elements are in place to deliver on the reform package. This section addresses the RfP questions (d), (e) and (f).
- Section 8: *Project management* provides the findings of our evaluation of the programme management arrangements in place to support the delivery of change. This section addresses the RfP questions (d), (g), (h), (i) and (j).
- Section 9: This section presents our recommendations for the way forward and highlights the enablers to be considered in order for the WHO reform to be sustainable and successful in the long-term.

Throughout the document, we have summarised key learnings and attention points as follows:

- In green boxes: achievements and enablers that are in place.
- In red boxes: constraints, challenges and barriers to successful implementation of the reform.

Upon finalisation of this report, we will also prepare a summary presentation for the attention of the EB of WHO at its 134th session in January 2014.

3. Overall progress on the reform

3.1. Reform progress to date

Various elements of change to the WHO organisational structure and work practices in the making since 2009-2010 have been grouped over time under a cohesive umbrella called Reform. The resulting reform ‘package’, described in the HLIP first presented to Member States in 2012, consists of:

- 4 (also called 3 + 1 by the Secretariat) reform areas, namely programmatic priority-setting, governance, managerial and change management
- 13 (also called 12 + 1 by the Secretariat) reform initiatives each underpinned by specific outcomes and indicators
- 51 outputs organised under the reform outcomes
- 143 key deliverables supporting the reform outputs

A challenge for Member States, WHO management or for the IET is to find an adequate level of granularity to track progress. The amount of information one has to absorb and the content of what is reported vary greatly depending on whether progress is reported at the level of one of the four reform areas or if reporting is done against the 143 discrete deliverables outlined in the HLIP.

Another challenge is to assess progress against clear targets and indicators. This task is facilitated through the evaluation framework used by the IET which breaks down the progress of each initiative and output along the five stages of transformation outlined in **Figure 1** in the previous section. The resulting status does not however fully reconcile with the reporting from the Secretariat to Member States, which to date has focused on the progress towards completion of key deliverables. Refer to section 9.2.1 for the related recommendation.

3.1.1. Overall reform status

Taking into account the above challenges, we sought to provide a synoptic view of the reform status that could capture both the detailed information of the reform programme, but also be user-friendly and fit on one page. We also sought to remain consistent with how the WHO reform is being presented to Member States and staff, notably by using the wheel of the ‘*WHO Reform story*’.

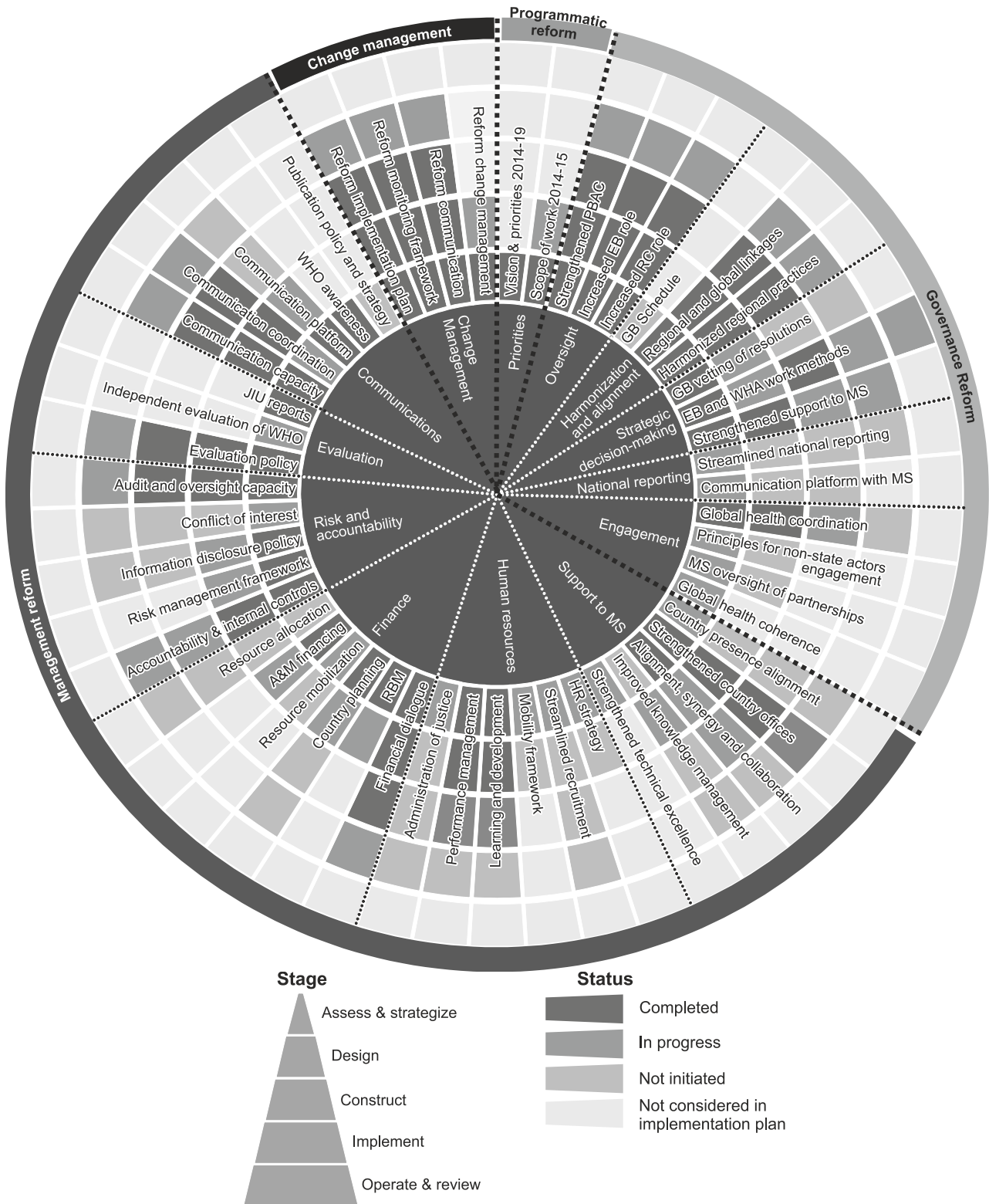
Figure 2 presented in the next page is a result of discussions with Business Owners (BOs) and the RST on progress made in each reform initiative, related outputs and key deliverables, and a desk review of documentation available for each reform initiative.

The chart is structured as follows:

- The wheel is split into four sections, each representing a reform area.
- Each reform area is broken down into its reform initiatives presented at the centre of the wheel and outputs presented in the middle section of the wheel, as documented in the HLIP.

- Progress for each output is shown using five segments, each representing a stage of the transformation process and ranging from the 'Assess and Strategise' stage located in the inner circle, to 'Design', 'Construct', 'Implement' and finally the 'Operate and Review' stage located in the outer circle.
- Finally, the colour coding tags the status of progress for each output in each of the five transformation stages. Four states describe the status of progress: 1) green (completed); 2) orange (underway); 3) dark grey (planned but not initiated) and 4) light grey (where no deliverable or output corresponding to this stage is mentioned in the HLIP).

Figure 2. Summary of reform status



3.1.2. Analysis of the progress on reform

Overall, we make the following observations:

The status varies greatly between reform areas and within reform initiatives. This heterogeneous status is illustrative of on one hand, the priorities of the reform, e.g. some progress has been made on financial and budgeting matters, given that the reform agenda has historically been rooted in the need to address the financial vulnerability. On the other hand, it is also reflective of the complexity of the tasks to be undertaken (e.g. streamlining of national reporting) and barriers to change, both within the Secretariat (e.g. improving human resource management), Member States (e.g. the terms of engagement with non-state actors), and externally (e.g. UN HR contract rules).

- **Programmatic priority-setting.** The 12th GPW was developed on the basis of new criteria for prioritisation and results-chain. The PB 2014-15, albeit a transitional budget, was unanimously endorsed by Member States. The operational planning 2014-15 was rolled-out but implementation is yet to commence. Implementation of the programme budget will be the test for the WHO to demonstrate greater coherence, focus and alignment across the three levels of the organisation.
- **Governance** reform on the other hand has made comparatively slow progress, in particular in the area of engagement with non-state actors. On the other hand, the reform has been able to make some quick wins with the review of governing bodies procedures (e.g. traffic light system in governing body meetings). The challenge in this area is now to ensure that the actual work of Member States moves towards more strategic focused working arrangements and better coordination between the EB, WHA and Regional Committees. Refer to section 9.1.2 for the related recommendation.
- In terms of the **managerial** reform, WHO needs to overcome challenges in its human resource management policies and practices if it is to reorient the Secretariat towards a better performing and relevant organisation. Merit-based promotion and career management are just beginning in the Organization, and few incentives exist for good performance. Critical to this area is the need for the Secretariat to focus on country presence alignment and strengthened technical excellence, which are also lagging behind. Refer to section 9.2.2 for the related recommendation.
- In relation to **change management**, the elected leadership at HQ and regional level has demonstrated a strong commitment to reform. However, a change management approach is not currently being followed to address the needs of all the change agent groups key to the reform, notably the technical Directors and WRs in the Organization. Refer to section 9.3.3 and 9.3.4 for the related recommendation.

Only 33% of reform outputs have reached their implementation stage. It is important to re-emphasise that the reform agenda is just starting implementation and that there are high expectations for its execution. We note, however, that implementing change in any organisation, and particularly one as complex as WHO, will take several years. We highlight three major points:

- *The Secretariat will need to manage the expectation of Member States* to show progress whilst also ensuring that drive and momentum are maintained in a sustainable way and benefits are accrued along the way. The institutionalisation of key reform areas prior to the end of the DG's second term in mid-2017 will be of particular importance to ensure the reform is sustainable in the long-term.

- *Change will place a considerable time burden and impact on WHO staff, management and Member States given that a number of initiatives will enter into implementation state concurrently in 2014. Tight coordination and alignment from the Secretariat will therefore be paramount.*
- *The majority of outputs and deliverables are focused on strategy and policy development and may not consider all the steps required to lead into implementation and institutionalisation of the change. We have categorised a majority of outputs and deliverables as falling into the initial categories of transformation, i.e. 'Assess and Strategise' and 'Design' phases. This suggests a need to look forward and detail the next steps for implementation.*

Some initiatives are going beyond the deliverables outlined in the implementation plan. Some BOs are taking some activities forward beyond the deliverables contained in the HLIP. This is the case for example for the evaluation initiative which has developed a handbook on evaluation to promote the culture of evaluation in the organisation, or for the accountability and internal controls initiatives with the launch of a Dashboard to track administrative Key Performance Indicators. These additional outputs are not necessarily visible at the time of reporting on the status of implementation of the reform programme; however it is comforting to see BOs drive the implementation forward.

The communication, knowledge management and human resources reform initiatives have started with the implementation stage without having addressed the 'Assess and Strategise' phase. This is understandable given the short term changes that were required.

Overall the reform has made progress in implementing short-term initiatives. WHO has yet to address core questions such as the articulation of its delivery model at country-level, how it intends to engage with non-state actors or how it will concretely improve its internal governance mechanisms.

A detailed review of progress, achievements and points for consideration for each reform area is provided in sections 4 to 8.

3.2. Stage 1 Evaluation and JIU recommendations

The terms of reference for the 'Independent evaluation of the WHO reform: stage two' contain a requirement for the IET to follow-up on the implementation of the recommendations of two important pieces of work issued in recent years-among others which have contributed to the debate on WHO's performance in the past years-both with the overarching goal of evaluating the steps and direction taken by WHO to reform its organisational structure. The underlying driver of these two studies was the call from Member States for improved and more effective governance and management of the WHO.

The first one is the stage 1 evaluation of the reform led by the Comptroller and Auditor General of India, between February and March 2012², to evaluate the completeness and adequacy of the reform agenda, and to ensure WHO had identified the right priorities for change.

The second is the review by the Joint Inspection Unit of the United Nations in 2012³ which conducted a thorough review of the administrative practices and level of decentralisation at the WHO Secretariat.

² WHO, WHO reform, Independent evaluation report: stage one, 65th World Health Assembly, A65/5 Add.2, 18 May 2012.

³ Joint Inspection Unit of the United Nations, Review of management, administration and decentralisation in the World Health Organization (WHO), 2012.

This section therefore identifies the status of implementation of each recommendation as part of the ongoing activities on reform. We have used the same criteria for assessing the course of implementation of recommendations as those used for evaluating the reform status in Figure 2. In addition, we have included the additional ‘Partially completed’ status for those recommendations that have not been fully addressed.

- *Completed*: The recommendation has been considered by the WHO and fully implemented.
- *Partially completed*: some elements of the recommendation have been addressed while others have not.
- *In progress*: The recommendation has been considered by the WHO and is currently being addressed.
- *Not initiated*: The implementation of the recommendation has not formally started.

The table below summarises the status of actions taken to address these recommendations:

Report	Not initiated	In progress	Partially completed	Completed	Total
Stage 1 evaluation	1	7	1	4	13
JIU	6	9	4	2	21
Total	7	16	5	6	34

So far, 21% of the recommendations of the stage 1 evaluation and of the JIU review have been fully completed, demonstrating that reform is still at the start of implementation.

3.2.1. Status of implementation of the Stage 1 Evaluation recommendations

The Secretariat has mapped the thirteen recommendations from the stage 1 evaluation against the reform initiatives to form part of the HLIP. We detail in the table below our assessment of the status of this implementation. Based on our review of the recommendations, the IET has identified some adjustments to the categorisation of the recommendations against the HLIP:

- Recommendation 2, on the re-design of the accountability and responsibility framework, was mapped by the RST against the reform initiative ‘Support to Member States’ however the IET considers that it also encompasses aspects of ‘Accountability and transparency’, ‘Human resources’ and ‘Finance’.
- Recommendation 6, on fine-tuning existing internal procedures, was mapped by the RST against the reform initiative ‘Change Management’ when in fact the IET considers that it should be mapped to ‘Accountability and transparency’ as it relates to managerial internal procedures.

Table 1. Implementation of Stage 1 recommendations

Stage 1 Recommendations	Status	Analysis
1. Interlinkages among governing bodies at headquarters and regional offices have to be carefully created, as these would have the far-reaching impact on organizational coherence and would provide the Organization with a strategic focus.	Partially completed	<p>Interlinkages between the EB and WHA at global level and the Regional Committees (RC) at the regional level have been strengthened in all regions through the revision of rules and procedures, the start of regular reporting of the RC Chairs to the EB and more disciplined agenda-setting.</p> <p>There continues to be a need to define a mechanism to ensure issues and resolutions made at the global level are considered and implemented in a systematic fashion at the regional level.</p> <p><i>Refer to section 5.2.2 for further detail.</i></p>
2. The accountability and responsibility structures for the three layers of governance, i.e., country offices, regional offices and global head office would need to be redesigned, keeping in view, the new programmatic approach, resource allocation mechanism and country focus on programme planning and delivery. A robust results-based management system and an effective performance management and development system could provide the requisite links.	In progress	<p>This recommendation is addressed in a number of reform initiatives including:</p> <ul style="list-style-type: none"> - the clarification of the roles and responsibilities across the three levels of the organisation - accountability and internal controls - resource allocation - results-based management - Performance Management and Development System (PMDS) <p>The taskforce on the three levels of the organisation defined the roles and responsibilities for each of the six core functions of WHO. The Secretariat made efforts to strengthen the accountability systems in place at WHO. The introduction of the GSM system prior to the start of the reform process has brought about greater transparency and helped streamline administrative processes. As part of the reform, GMG is developing an internal controls framework and has set-up a new dashboard in July 2013 to track key management performance indicators. The HR Department plans to launch an enhanced PMDS tool in January 2014.</p> <p>Progress is underway on results-based management, with the definition of the new results-chain that underpins the 12th GPW and PB 2014-15. Key to institutionalising a culture of accountability for results will be a mind-shift at staff level.</p> <p><i>Refer to section 6.2.1 and 6.2.4 for further detail.</i></p>
3. Country focus seems to be a running theme in the reform proposal, starting from programme formulation to resource allocation to programme delivery. A detailed strategy interlinking various aspects of proposed changes along with	Not initiated	<p>As mentioned above, the definition of the allocation of roles and responsibilities between the three levels of the organisation was completed and integrated into the PB, which forms the starting point for this recommendation.</p> <p>The Country Coordination and United Nations Collaboration (CCU) at HQ was moved to the Director General Office and is taking on the review of the country focus strategy, to address the need for better alignment of country support to Member States. This activity is under development at</p>

Stage 1 Recommendations	Status	Analysis
structural and procedural support needs to be formulated.		<p>the time of the writing the report.</p> <p><i>Refer to section 6.2.1 for further detail.</i></p>
4. A regular feedback mechanism is a must for providing assurance about the activities of the Organization. WHO needs to have an evaluation policy with clear deliverables, for conducting programme evaluations at regular intervals.	Completed	<p>The WHO evaluation policy was endorsed by the WHA in May 2012, with programme evaluations as the centre piece. This initiative also moved ahead by establishing the Global Network on Evaluation (GNE) to foster the evaluation culture across the three levels of the organisation.</p> <p>However there remains the need for the organisation to address results from programme evaluations in a comprehensive manner that is linked to Results Based Management (RBM) in the future.</p> <p><i>Refer to section 6.2.5 for further detail.</i></p>
5. Such wide-ranging changes require acceptance at various levels. An advocacy plan, to explain the implications of the change strategy, identification of change agents and a detailed change management plan would be required to implement the plan of action, after the approval is received from the appropriate authority.	In progress	<p>A change management plan⁴ and communication strategy⁵ were developed by the RST and serve as the initial foundations to managing change. Further, a focus group on communication was set up take stock on the reform communication efforts to date and areas for improvement.</p> <p>Efforts have mainly focused on communication; however a consolidated assessment of the desired or anticipated impact of each reform initiative on the WHO workforce and stakeholders is currently missing.</p> <p><i>Refer to section 8.2.3 for further detail.</i></p>
6. The existing internal procedures would require fine-tuning and adjustments for implementing the proposed changes, this would be especially important in implementing areas covered under 'managerial reforms'.	In progress	<p>See comments for Recommendation 2 above.</p>
7. It is understood that the reform proposal is still a work in progress, as various components of the proposal are at various stages of consideration. However, it is of paramount importance that desired outputs, outcomes and impact are identified, indicators to	Completed	<p>A monitoring framework for the HLIP exists⁶ that outlines the desired outputs for each reform initiative, against one and three years milestones, as well as expected impact. Efforts have been made to detail the results-chain and theory of change, although these still need to be reinforced.</p> <p>However, the IET notes that the feedback mechanism for reporting of reform progress is done in an ad-hoc fashion (where upward reporting from BO to the RST is predominant) and is largely Member States focused (through reporting to governing bodies). Monitoring and evaluating reform progress is also a challenge given the size of the reform</p>

⁴ WHO, WHO Reform, A Strategy for Managing Change.

⁵ WHO, Engagement and communication for WHO Reform, November 2012.

⁶ WHO reform, High-level implementation and monitoring framework, 65th World Health Assembly, 16 May 2012.

Stage 1 Recommendations	Status	Analysis
measure these are designed and a monitoring and feedback mechanism is put in place.		agenda. <i>Refer to section 7.2.4 for further detail.</i>
8. The Organization is proposing a comprehensive reform programme, which involves action on a large number of fronts. It is recommended that a prioritization plan may be prepared to allow a smooth and gradual shift. This plan could also distinguish between the elements of changes proposed on the basis of level of approvals required.	In progress	The HLIP includes a sequenced the timing of the outputs to be delivered. It presents some shortcomings however, particularly in defining which initiatives are of priority in timing and strategic focus. <i>Refer to section 7.2.2 for further detail.</i>
9. The implementation strategy should indicate resource requirements in financial, human, time and technical terms.	Completed	Each reform initiative has been assigned a BOs and the budget (funds received) for the reform agenda is clearly laid out. Some BOs have also already defined their own action plans. However, there has not been a systematic approach for resourcing, planning, implementing and monitoring the reform initiatives. This has constrained progress on some activities and the timeliness and quality of the consultations. <i>Refer to section 7.2.3 and 7.2.6 for further detail.</i>
10. Consultations with non-Member State donors may be considered to understand their concerns. This feedback might be important for preparing a realistic strategy.	Completed	The Financing Dialogue of June 2013 has made a point to broaden the donor base, outside traditional donors and discussions have taken place in preparation to the second session planned in November 2013. <i>Refer to section 6.2.3 for further detail.</i>
11. The success of the proposal would also be dependent on carrying out of changes in human resources policies. Given the fact that human resources policies do have inbuilt rigidities, WHO may have to resort to innovative solutions. It is recommended that best practices in similarly placed organizations may be	In progress	This recommendation is addressed by the HR initiatives, which have made slow progress: <ul style="list-style-type: none"> - An HR strategy is under development at the time the evaluation took place - A global mobility policy is under development since July 2013 - A global recruitment policy is planned to be launched end 2013 - WHO has gone through an initial reform of its contracts, by establishing stricter criteria for granting continuing appointments

Stage 1 Recommendations	Status	Analysis
considered.		<p>- An enhanced PMDS is planned to be launched by end 2013</p> <p>As all these HR policies are being developed simultaneously, the DG will need to achieve coherence and lead needed change in this critical component of the reform. The appointment of the new HR Director in September 2013 will address the challenge of transitional leadership.</p> <p><i>Refer to section 6.2.2 for further detail.</i></p>
12. The success of any change strategy is directly correlated to understanding of its gains by the stakeholders. It is suggested that a regular communication should be maintained with all concerned on the progress of the reform proposal, which would help in creating the right environment for implementation.	In progress	<p>Efforts have been made to address reform communication by issuing bi-annual newsletters to staff to better explain the content and details of the reform agenda. A change and communication strategy, entitled '<i>WHO Reform, A Strategy for Managing Change</i>', was developed by the RST. As well, a focus group on communication was set up take stock on the reform communication efforts to date and areas for improvement.</p> <p>An analysis of the benefits for each group of stakeholders, internal and external has not been done as of yet however.</p> <p><i>Refer to section 8.2.2 and 8.2.4 for further detail.</i></p>
13. The proposed reform proposal has highly interdependent components, the success of the process would require that this interdependence is recognised and woven in the implementation strategy.	In progress	<p>The HLIP contains a table of dependencies between the various reform initiatives. Also the RST and GPG play a role in ensuring coherence and coordination between initiatives. The new project management approach document⁷ to the reform agenda is aimed at recognising interdependencies and addressing bottlenecks.</p> <p>However dependencies are only identified at a high level and are not formally managed using structured project management discipline. Operational dependencies (e.g. on people) are not included.</p> <p><i>Refer to section 7.2.5 for further detail.</i></p>

3.2.2. Status of implementation of the JIU recommendations

A total of 23 recommendations were issued by the JIU in its 2012 'Review of Management, Administration and Decentralization in the World Health Organization (WHO)' that are relevant to the WHO reform.

Our assessment of the status of this implementation is detailed in Table 2. Appendix 3 of the HLIP, '*Inclusion of Recommendations of the United Nations Joint Inspection Unit on Administration and Decentralization in WHO*' maps the recommendations of the review to each of the reform initiatives that are directly relevant. Based on a review of the recommendations, the IET has identified some adjustments to the categorisation of the recommendations against the HLIP which are presented as follows:

- In the section 'Administration', recommendation 2, on the number of ADG positions, their job description and selection process, was mapped by the RST against the reform initiative 'Human Resources' however

⁷ WHO, WHO reform Programme Management Approach- Reporting, 2013

the IET considers that it is more relevant to the aspect of ‘Accountability and transparency’ given the aspect of accountability between the ADGs and the DG.

- In the section ‘Decentralisation’, recommendation 1, on the need for the EB to conduct a comprehensive review of the governance process at regional level and put forward concrete proposals to improve the functioning of Regional Committees and subcommittees, was mapped by the RST against the reform initiative ‘Strategic decision-making’ when the IET considers that it should be mapped to ‘Oversight’ and ‘Harmonisation and alignment’ as it is more relevant to these reform initiatives.

The same criteria considered for assessing the course of implementation of recommendations of stage 1 are used here.

Table 2. Implementation of JIU recommendations

JIU Recommendations	Status	Analysis
Administration		
1. The Director-General should review the current headquarters organizational structure to enhance management and operational effectiveness in line with the changes to be approved in the ongoing reform process.	In progress	<p>Efforts have been made by the DG to bring about alignment to the programmatic and organisational structure at HQ, with the objective to shift the structure of the organisation, to more matrix reporting. A number of changes have been initiated, including:</p> <ul style="list-style-type: none"> • Re-organisation is taking place to re-group programmatic areas under the most relevant ADG, e.g. the consolidation of social determinants of health within the PHE Department; • The GPG commissioned a study on strengthening and institutionalizing the roles and responsibilities of the Category Networks was commissioned by the GPG to manage and oversee the work within each of the six categories of work in the PB 2014–2015. The study is expected to be finalised by end January 2014. Category Networks are being implemented in order to enhance operations effectiveness in a more vertical manner; • Re-structuring of the DGO to improve management effectiveness and the creation of separate budget centres for each unit of the DGO. <p>Further work is needed to operationalise and monitor the compliance with the new roles and responsibilities across the levels of the organisation.</p> <p><i>Refer to section 6.2.1 for further detail.</i></p>
2. In the course of the ongoing management reform, the Director-General should review the number of ADG positions, formulate their job	Partially completed	The JIU pointed out that the WHO had the highest number of ungraded positions among senior management compared to other UN agencies. In light of this:

JIU Recommendations	Status	Analysis
<p>descriptions and inform the Executive Board about measures to enhance the transparency of their selection and appointment process.</p>		<ul style="list-style-type: none"> The number of ADG positions has been reduced overtime from 12 to 8, with one ADG per Category of work, except for category 5 and 6 where there are 2 ADGs co-leading the work. This was done to ensure greater cohesiveness and alignment to the new categories of work; An accountability compact between the DG and ADGs is under development⁸ and sets the roles and functions, expected standards in each of the key competencies and behaviours and metrics for management. This is based on a compact introduced by the UN Secretary-General and will be launched in January of 2014; WHO has taken the stance that ADGs, DDG and Deputy Regional Directors are directly appointed at the discretion of the DG and RDs. The contracts of these staff are co-terminus with the term of office of the DG or RD. <p><i>Refer to section 6.2.4 for further detail.</i></p>
<p>3. The Director-General should ensure that further development of the Global Management System be undertaken on the basis of a comprehensive, Organization-wide independent evaluation of the design, operational experiences and lessons learned.</p>	Not initiated	The GSM was upgraded in 2012 and the review is planned to start in 2015.
<p>4. The Director-General should elaborate a long-term strategy for the functions and operation of the Global Service Centre, including its governance and financing.</p>	Not initiated	This activity has been endorsed but is planned to start in 2014.
<p>5. The Director-General should commission an external evaluation of the preparation of publications in WHO.</p>	Not initiated	WHO has endorsed this recommendation and will follow the evaluation policy, although it will not necessarily be an external one. The evaluation of publications has been proposed in the 2014-15 evaluation workplan.
<p>6. The Director-General should take measures to strengthen the central content management and ownership of the WHO intranet and ensure that the staff have better knowledge and access to use available professional information existing in the</p>	Partially completed	<p>Some progress has been made in this area through the development of a public platform on the WHO website to offer a one stop shop for all WHO documentation. Ownership of the intranet has yet to be defined.</p> <p><i>Refer to section 6.2.1 for further detail.</i></p>

⁸ WHO Accountability Compact between Assistant Director General and Dr Margaret Chan, Director General, World Health Organization, 2013.

JIU Recommendations	Status	Analysis
Organization.		
7. The Director-General should elaborate a concrete action plan to ensure better monitoring and a more consistent implementation of human resources policies across the Organization	Not initiated	<p>The first step to addressing this recommendation is the development of an HR strategy which will be presented to the GPG in November 2013.</p> <p><i>Refer to item 11 of Stage 1 recommendations for further detail.</i></p>
8. The Director-General should present a contractual model that adequately reflects the changing staffing needs and takes into account the existing financing modalities.	Partially completed	<p>Addressing this recommendation will be dependent on the completion of Rec. 7 above, which will lay the strategic guidance for a reform of contractual models at WHO. The WHO has already gone through an initial reform of its contracts, through the establishment of 3 types of contracts: 1) short-term, 2) fixed-term with termination, 3) fixed-term continuing. Changes on continuing appointments have been applied to the Staff rules (since January 2013), specifically establishing stricter criteria for granting continuing appointments and extending the duration of fixed- contracts beyond 5 years to retain skilled staff within the organisation.</p> <p><i>Refer to section 6.2.2 for further detail.</i></p>
9. The Director-General in consultation with Regional Directors should elaborate and promote an Organization-wide mobility policy across all three levels of the organization with concrete targets and a set of indicators to be monitored.	In progress	<p>While mobility has stalled at the global level, some regions are making better progress (e.g. WPRO)</p> <p>HQ has embarked in July 2013 on the process of developing a mobility strategy for the global level. This was still under development at the time of writing the report.</p> <p><i>Refer to section 6.2.2 for further detail.</i></p>
10. The Director-General together with the Regional Directors concerned should elaborate an action plan with targets and indicators to improve gender balance and report on its implementation to the Executive Board as part of regular human resources reporting.	In progress	<p>This recommendation is being addressed through the development of the HR strategy. WHO has adhered to the United Nations System-wide Action Plan (UN-SWAP) framework on gender equality in April 2012 and is expected to achieve gender parity in the workforce by 2017.⁹</p>
11. The Executive Board should recommend that Member States support the Director-General's efforts aimed at increasing the predictability of financing, including through providing more flexible and multi-year voluntary contributions.	In progress	<p>Through the adoption by Member States of the WHA resolution on the Financing Dialogue, this recommendation has been addressed. Against target, the Secretariat launched a Financing Dialogue in June 2013 and a second one is planned for November 2013 with the aim to define a sustainable funding model for WHO.</p> <p><i>Refer to section 6.2.3 for further detail.</i></p>
12. The Director-General should establish an appropriate formal mechanism for	In	<p>This recommendation is aimed to address the aspect of budget allocation and availability in the PB. While budget allocation for</p>

⁹ WHO, Human resources: annual report, Report by the Secretariat, 66th World Health Assembly, 14 May 2013.

JIU Recommendations	Status	Analysis
the resource allocation process to improve transparency and participation of different players of the Organization.	progress	<p>2014-15 has been primarily done based on historical data, the process is currently under consideration with the aim to agree on a revamped budget allocation methodology by May 2014. This is in line with the DG's decisions on assessed contributions (ACs) to be more transparent. A proposal on the use of ACs is expected to be presented at the Financing Dialogue in November 2013.</p> <p><i>Refer to section 6.2.3 for further detail.</i></p>
13. The Director-General should ensure that the compliance and control mechanisms at different levels be integrated into a coherent and comprehensive internal control framework.	In progress	<p>GMG led the development of the '<i>Internal Management Control Framework</i>', developed in July 2013. This document clarifies the objectives and scope of an internal controls framework at WHO. It is now in the process of being rolled-out.</p> <p>Also, the new Compliance, risk management and ethics Department was established as of October 2013 to support overall monitoring of compliance.</p> <p><i>Refer to section 6.2.4 for further detail.</i></p>
14. The Director-General should include the global information technology programmes in the agenda of the Global Policy Group to ensure that the necessary support and resources are provided.	Completed	Starting 2014, information technology will be a standing item of the GPG meeting. Further, a report from the GPG will be informing the Programme, Budget and Administration Committee of the Executive Board (PBAC).
15. The Director-General should initiate a UNEG peer review on the evaluation function of WHO so as to benefit from the established best practices in the United Nations system and to fully align the evaluation function of WHO with the UNEG norms and standards and present this peer review to the Executive Board no later than 2014.	Not initiated	In April 2013, WHO requested a peer review of the evaluation function during the Annual General Assembly to the UNEG, which is scheduled for end of 2014. Findings from the peer review are to be reported to the EB in 2015. In addition, the JIU is currently reviewing the WHO evaluation function, together with that of other UN agencies.
Decentralisation		
1. The Executive Board should complete, in the context of the current WHO reform process, a comprehensive review of the governance process at regional level and put forward concrete proposals to improve the functioning of Regional Committees and subcommittees and finalise the harmonization of their rules of procedure for the consideration of Regional Committees.	Completed	<p>Rules and procedures of RCs have been revisited in all regions, addressing the three areas below:</p> <ul style="list-style-type: none"> <i>The nomination process for RDs.</i> This was to improve and bring about transparency to the selection process of RDs. Most recently, the AFRO and SEARO regions completed their revisions in September 2013. <i>The participation of observers at RCs.</i> The point here has been to broaden the participation of observers in Regional Committee to include UN agencies, NGOs, states that are not Member States and other organisations as seen fit.

JIU Recommendations	Status	Analysis
		<ul style="list-style-type: none"> <li data-bbox="774 338 1439 562">• <i>The review of credentials of delegates.</i> Following the decision by the WHA65¹⁰ requesting WHO regions to formalise the review of credentials of delegates through a credential committee or officers of the RCs, regions have started the implementation of mechanisms to screen the credentials of Member States delegates participating in RCs, for their technical validity. <p data-bbox="774 584 1193 618"><i>Refer to section 5.2.2 for further detail.</i></p>
<p data-bbox="129 651 598 869">2. The Director-General, in consultation with the Assistant Directors-General and Regional Directors, should monitor the set-up and functioning of networks and annual meetings by technical and administrative areas of work at the three levels of the Organization.</p>	Partially completed	<p data-bbox="758 651 1455 869">The GPG commissioned in May 2013¹¹ a study on strengthening and institutionalising the roles and responsibilities of the Category Networks set up to manage and oversee the work within each of the six categories of work in the PB 2014–2015. The study is expected to be completed in January 2014. This will provide the basis for increased oversight and monitoring of the Category Networks.</p> <p data-bbox="758 891 1185 925"><i>Refer to section 6.2.1 for further detail</i></p>
<p data-bbox="129 965 598 1182">3. The Director-General and Regional Directors, in consultation with Member States, should agree on criteria for a minimum and robust country presence. Criteria and procedures should also be developed to open and close sub-offices subject to changing needs.</p>	In progress	<p data-bbox="758 965 1455 1115">The CCU at HQ developed in October 2013 an inception paper that serves as the basis for developing a new country focus strategy and presents proposals for implementing the WHO reform at country-level¹². This paper will be discussed at the WR Meeting in November 2013.</p> <p data-bbox="758 1137 1185 1171"><i>Refer to section 6.2.1 for further detail</i></p>
<p data-bbox="129 1211 598 1473">4. The Director-General and Regional Directors should take action as appropriate to reposition the country support units/functions at headquarters and regions more strategically, enhance their capacity and leverage their role in harmonization and decision-making.</p>	In progress	<p data-bbox="758 1211 1455 1518">The Director-General Office underwent a restructuring in September 2013, with CCU now being formally part of the DGO. The re-positioning of the Country Support function at regional and country level will be addressed in the revised country focus strategy. Since 2009, 4 ROs have set-up dedicated Country Support Units (CSU) while in the two other regions, this function is part of planning. CSUs have proved to be useful in supporting country offices and monitoring their performance, however their systemisation has yet to happen across all regions.</p> <p data-bbox="758 1541 1185 1574"><i>Refer to section 6.2.1 for further detail</i></p>
<p data-bbox="129 1592 598 1809">5. The Director-General, in consultation with the Global Policy Group, should revise the existing categories, grades and delegation of authority of heads of country offices in line with the size, capacity and operational needs of the</p>	Not initiated	<p data-bbox="758 1592 1455 1809">The topic has been part of GPG meetings¹³ and is planned to be addressed by the country focus strategy. It aims to address the typology of country offices and WRs. We note that some regions have set-up categorisations of country offices, based on their operational and technical needs which is a step ahead and will need to be harmonised into a holistic approach.</p>

¹⁰ WHO, 65th World Health Assembly, Resolutions and decisions, WHA65/2012/REC/1, 21-26 May 2012.

¹¹ WHO, Draft workplan for study on strengthening and institutionalization of Category Networks, June 2013.

¹² WHO, WHO reform at country level, Country Coordination and United Nations Collaboration, October 2013.

¹³ WHO, Notes and Decisions from the Global Policy Group Retreat, 12-13 March 2013, Chiang Mai, Thailand.

JIU Recommendations	Status	Analysis
country offices.		<i>Refer to section 6.2.1 for further detail</i>
6. The Director-General and Regional Directors should include in their programme budgets and work plans specific objectives, activities and indicators relating to the promotion of inter-country and interregional cooperation and ensure that adequate funding is foreseen for their implementation.	In progress	The PB does not present specific budget envelopes on inter-regional cooperation. However, each category of work sets out a section entitled ‘ <i>Linkages with other Programmes and Partners</i> ’ which outlines with whom WHO will collaborate to achieve each category outcomes. Working with partners and country/regional cooperation mechanisms is also made apparent at the level of the description of the roles and responsibilities of the three levels of the organisation and is already taking place. Budgets allocated for interregional collaboration will be defined as part of operational planning which is underway at the time of writing this report.
		<i>Refer to section 4.2.2 for further detail</i>

NB: we did not follow up on the recommendations relating to building management (“The Director-General should ensure that a long-term policy on building management be elaborated and its implementation supported by organization-wide standards and guidance” and “The World Health Assembly should review the long-term policy on building management and to provide the necessary funding for its implementation.”) which are not part of the scope of reform although the Financing Dialogue should address the financing of the Capital Master Plan in the future.

4. Programmatic reform

4.1. Background

This area of reform relates to priority-setting, with the objective of refocusing the efforts of WHO on its comparative advantage and to establish a process for determining programmatic priorities.

Underlying this focus has been a general consensus among Member States, WHO officials and stakeholders that one of the biggest challenges facing WHO has included a lack of clearly defined organisational priorities and insufficient strategic priority-setting. As a result, WHO has been stretching its resources across 13 strategic objectives and numerous programmatic areas, which constrains its ability to achieve results and impact.

This area of the reform is underpinned by one outcome - *WHO's priorities defined and addressed in a systematic, transparent, and focused manner and financed in alignment with agreed priorities*- and two major outputs, i.e. the delivery of the GPW 2014-19 and the PB 2014-15. Both outputs were produced in parallel, which required agility in ensuring consistency between the documents.

A third output, the operational plan for 2014-15, was initiated once both GPW and PB were endorsed by Member States in May 2013. It is still underway at the time of writing the present report. It is not formally identified in the HLIP. We however comment on this process as 1) it forms a natural next step once GPW and PB are defined, and 2) the operational planning crystallises the operational implications and challenges of the direction set out in the GPW and PB. The nature of the operational planning process, described as top-down by several, is looked into greater details in Section 4.1.1.

The execution of the above was coordinated by the General Management Group (GMG)/ Planning Resource Coordination and Performance Monitoring (PRP). Given the strategic nature of these discussions, the Director General and the DGO played an active role. These processes have also placed emphasis on inclusive consultations with Member States, RCs, the WHO Secretariat and non-state actors, through a specific web-consultation.

4.2. Status



The GPW 14-19 and PB 14-15 planned in this initiative have been delivered and endorsed by Member States respectively at the 66th WHA in May 2013.

The operational planning for 2014-15, not formally identified as an output in the reform HLIP, but is underway at the time of writing of this report.

4.2.1. 12th general programme of work (GPW) 2014–2019

The definition of the GPW 2014-19 was initiated in February 2012 and finalised at the 66th WHA in January 2013.

The key characteristics of the process used to define the GPW relate to:

- *Being inclusive and consultative with Member States:* The IET received consistent positive feedback from Member States interviewed on the efforts made by the Secretariat to have an inclusive process and give Member States an opportunity to seek consensus and address strategic questions. For example, during the Regional Committee in EURO (September 2012), Member States comments to the draft GPW and PB were captured in two relevant reports. A number of Member States interviewed did, however comment that the pace at which consultations were conducted did not necessarily allow them to fully understand the implications of the choices they were making, notably given that the GPW and PB were defined concurrently. Some pointed out that the speed at which discussions were carried out in governing body meetings and consultation meetings was a challenge to create true ownership.
- *Being finalised in parallel to the Programme and Budget 2014-15:* this can be illustrative of a somewhat ad-hoc approach to planning resulted in both processes overlapping when they are by design meant to be sequential. However this overlap is partially a by-product of the consultative approach adopted by the Secretariat with Member States since several iterations of the GPW were produced prior to finalisation. The feedback obtained from Member States interviewed is that this required a degree of agility on Member States and Secretariat alike, notably given some inconsistencies between the two draft documents. Whilst some Member States mentioned they were fine with this approach, others mentioned the challenge this caused Member States in owning the content of the documents and having sufficient time to engage their respective Ministries and missions.

⇒ *The challenge to manage consultation and momentum is a consistent theme in the various interviews we have held within the Secretariat and Member States. The success of the programmatic reform amounts to more than adopting the GPW in record time. As reform moves forward it is key to ensure appropriate time and support are provided to Member States to ensure their ownership. Refer to section 9.1.2 for the related recommendation.*

- *Internal Category Networks played a major role in producing the GPW*, based on a survey conducted by the Secretariat. Those networks played a role in the definition of the PB 14-15 and subsequent operational planning (refer page 61 for further details on Category Networks).

In terms of structure, the GPW 2014-19 is based on some key new approaches:

- It clearly articulates the *global health context and challenges* that need to be tackled.
- It re-emphasises *WHO's core functions* which include 1) providing leadership, 2) shaping the research agenda, 3) setting norms and standards, 4) articulating ethical and evidence-based policy options, 5) providing technical support and 6) monitoring the health situation.
- It is guided by *criteria for priority-setting* agreed upfront by Member States and defines *six leadership priorities* of the WHO for the future years ahead: advancing universal health coverage; health-related millennium development goals; addressing the challenges of non-communicable diseases; implementing the provisions of the International Health Regulations (IHR), increasing access to essential, high quality

and affordable medical products, and addressing the social, economic and environmental determinants of health. These do correspond to what the academic literature and global health governance specialists interviewed by the IET identify as key challenges where global governance is required and where WHO should demonstrate leadership and relevance.

- It organises WHO's activity along *six new categories of work*, thirty programme areas and eighty-two programmatic outputs. Whilst leadership priorities are intended to 'shape the global debate', the categories relate to the operational work by the Secretariat. These newly defined categories appear to be broad umbrellas and the number of programme areas, thirty, continues to be large and cover a wide range of themes and related services. This questions whether prioritisation is actually happening. This was highlighted in the report of the Regional Committees to the EB (January 2012) where '*Members asked for clarification on what was not to be prioritised, and they expressed concern about the number of priorities.*' This is all the more a concern that the GPW does not articulate how the leadership priorities will be supported operationally. This linkage is essential to ensure the Secretariat operationalises adequately the leadership priorities for global health.

⇒ *Despite existing criteria used for priority-setting, the inevitable trade-off between Member States expectations on one hand is not resulting in the focus requested by Member States on the other hand. While the priority-setting exercise was a good step in the right direction, more work needs to be done to align Member States expectations and decision making in such a way that increased focus to WHO activities actually happens. Refer to section 9.1.2 for the related recommendation.*

⇒ *Stronger linkages between the six categories of work and the leadership priorities would enable greater organisational coherence with the strategic direction. Refer to section 9.2.2 for the related recommendation.*

- The 12th GPW is underpinned by a *revised results chain framework*: improving WHO results-chain was a consistent feedback in prior WHO evaluations and reviews, e.g. the 2012 JIU 'Review of Management, Administration and decentralization in the World Health Organization (WHO)' and the 2011 DFID 'Multilateral Aid Review'. In November 2011 a new result chain was defined which allocates accountability for outputs to the Secretariat and accountability for outcomes and impact to Member States and the Secretariat. Member States and donors interviewed welcomed the strengthened results-chain. Some limitations are, however, worth pointing out:
 - The 'comprehensive theory of change' articulated in the GPW is more anecdotal than systematic. As a consequence, outputs and outcomes are not formally linked to the impact goals presented in the 12th GPW. The theory of change is high-level in nature and would benefit from being tightened. This would provide a strengthened mechanism to align and prioritise activities.
 - While some leadership priorities can easily be traced back to specific categories of work and linked to the related result-chain, we noted that this is not the case for advancing universal health coverage and increasing access to essential, high-quality and affordable medical products. The inputs, activities and outputs required to reach to the desired impact are not explicitly defined in the PB nor in the other accountability tools mentioned in the GPW (reform monitoring framework notably).
 - There is a lack of clarity in the document in relation to the respective accountability of Member States and Secretariat for the achievement of outcomes and impact. The results-chain clearly states that outcomes are the joint responsibility of the WHO Secretariat and Member States. However, what is expected of Ministries of Health (and non-health Ministries) in contributing to the theory of change is

not clearly described. Also some outcome indicators are hardly attributable to WHO's work alone. This is in particular the case for the programme area on social determinants and the specific outcome indicators 'net primary education enrolment rate' and 'number of slum dwellers with significant improvement in their living conditions'. It is also unclear how the accountabilities of the Secretariat and Member States are compared to those of external partners.

- ⇒ *The observed limitations in the theory of change are not conducive to the achievement of impact goals and WHO leadership priorities. Refer to section 9.2.1 for the related recommendation.*
- ⇒ *The joint accountabilities and responsibility framework the WHO has with stakeholders in meeting its set health outcomes need to be further defined if WHO is to achieve greater coherence in global health. Refer to section 9.2.1 and 9.2.2 for the related recommendations.*

Finally the far reaching impact of the GPW (and PB for that matter) on WHO's operating model is not discussed, notably:

- *Its operating model and service offering.* WHO offices tend to vary widely in size and capacity, but only rarely in relation to a country's actual needs. What was already pointed out in a 1997 study of WHO's support to country level¹⁴ remains valid today. The GPW does not describe how WHO's future structure will match the core services it delivers in varying country-settings, i.e. norm-setting, implementation, technical support, policy advice and advocacy. This is particularly important as Member States are going through wide-ranging economic, demographic and epidemiological changes that demand more resilient health systems and differentiated services.
- *Staff capability and skill set of its people.* Considering the recent reduction in staff, it is unclear whether the Secretariat can currently deliver on all of its priorities. We heard in our interviews that with restructuring, questions are now raised by Member States, Secretariat staff and NGOs as to whether the most appropriate capacity is in place to deliver concurrently on its historical areas of activity and on leadership priorities. The changing Member States needs will require staff to have more than scientific skills, e.g. economics, diplomatic and strategy-making. While re-profiling has happened in certain countries (e.g. Thailand, India), it has not been done at an organisation-wide level. The GPW does not address this important dimension.
- *Engagement model with the outside world.* The GPW does not provide clarity on how WHO intends to work with Ministries, UN agencies and other global health actors to execute the GPW. A critical aspect for WHO is to demonstrate how it differentiates itself from other development partners. In line with this, interviews have shown that Member States are increasingly expecting WHO to be at the centre of the coordination with the UN family and other development partners on health matters. Some Member States have mentioned the need for WHO to collaborate in a more active manner with regional groupings (e.g. UNASUR, ASEAN). The approach comes across as still inward-looking in nature, with the risk of having a less integrated WHO with decreased leveraging power and authority.

¹⁴ Ministry of Foreign Affairs Norway, Cooperation for Health Development, WHO's support to programmes at country level, September 1997.

⇒ WHO's current operating model does not provide confidence that the organisation will be capable to deliver against its expectations. A more robust articulation of how WHO will set out to deliver on GPW objectives, notably the alignment of country offices with country's needs, the definition of mechanisms for coordination across the levels and geographies of the organization and a better definition of WHO's strategic approach to partnering with stakeholders will position the Organization to be more effective.

⇒ Overall, despite the limitations mentioned, the GPW provides a robust basis for further declination of WHO's work in the 2014-19 period.

4.2.2. Programme and budget 2014–2015

The definition of the PB 2014-15 was initiated in 2012 and finalised at the 66th WHA in January 2013. The PB 2014–2015 is the first of three biennial budget cycles under the six-year GPW for 2014–2019.

The above comments regarding the challenges to balance consultation and momentum also apply here. For instance the GPG expressed in March 2013 at its Global Policy Group Retreat their concern that the draft of the PB did not sufficiently reflect the regional and country contribution to the work of the organisation and that the document should be circulated to Category Networks for review and validation.

In terms of process and structure of the PB, the following is worth pointing out:

- For the first time in WHO's history the WHA *approved the WHO budget in its entirety*. This facilitates the matching of funding to a realistic and credible programme budget and gives Member States an opportunity to monitor the budget in its entirety. Despite the process having been largely top-down, for Member States, the PB serves as an effective tool for accountability and transparency, programming and resource mobilisation.
- *Deliverables at country, regional and headquarter level have been standardised*, bringing transparency into the respective contribution of the various levels of organisation to specific outputs. Deliverables and outputs also link back consistently to the outcomes and impact described in the GPW. This provides for a tighter results- chain, a good starting point for allocating accountabilities across the organisation and tracking result achievements. It is also conducive to building donor trust – a sticky point over recent years and a requisite for predictable and flexible funding.
- *The budget provides for increased transparency*: it is broken down by region, level of the organisation and category and programme area. We note however that whilst baselines and targets for output indicators have been set, outputs are not costed in the PB.

⇒ The PB 2014-15 represents a laudable effort to demonstrate transparency in budget allocation which is conducive to increased trust by Member States and donors.

Of more concern to the IET is the actual content of the PB, where we emphasise the following:

- *The overall budget is flat (+0.5)*: in this context only marginal shifts in resource allocation can be used to align budget with leadership priorities. The ability to shift resources to priority areas is further constrained by the fact that a number of programmes run across several years and that a number of challenges relating to communicable diseases (such as eliminating mother to child transmission of HIV; addressing MDR-TB in prisons; or eliminating malaria related deaths in children) require continuing attention. Although relevant comparisons are difficult to make considering its global mandate, the WHO budget is comparable

to that of the Geneva university hospital which serves a local Geneva population of 200'000. In comparison, in 2012 the Global Fund received 3.6 billion USD from donors and disbursed 3.3 billion USD in grants to address three diseases¹⁵.

- *Within this flat budget some reallocation is happening, consistent with the direction set-out in the GPW: the budget for NCDs is up 20.5%, health systems 9.9% and eradicating polio, a leadership priority of continuing efforts to achieve health-related Millennium Development Goals, 17.4%. This shift is however less impressive in absolute terms: US\$54M, 41M and 104M respectively over the course of the biennium, i.e. 5% of the overall budget. Also the sub-area on identifying and addressing the social determinants of health, where WHO is attempting to position itself as a leader and global health convener and which is also one of its 6 leadership priorities has not experienced a material financial push. *The majority of reallocation is to the detriment of communicable diseases and emergency response.* The two categories see a reduction of their budget compared to 2012-2013 are:*

 - Communicable diseases (-7.9%), notably tuberculosis (-10.9%) and tropical disease research (-52.4%). This reflects on the one hand the material drops in prevalence in communicable disease in Asia and Latin America as well as WHO's changing direction and on the other hand, an underlying assumption that other players (i.e. Global Fund, World Bank, UNAIDS, Roll Back Malaria, PEPFAR) are taking an increased role in financing communicable diseases. However this assumption is not explicitly mentioned and is questionable. Also a large portion of African countries are now facing a double burden of disease, both communicable and non-communicable diseases and continue to require support from donors and the WHO on those health issues.
 - Outbreak and crisis response (-51.4% or -25% if combined to category 5 preparedness, surveillance and response). Whilst these are evidence of some strategic choices, it does demonstrate the challenge the Organisation is facing with delivering on all its commitments with a constrained budget. The risk is mitigated since there is no budget ceiling in case of an acute emergency. Further resource mobilisation at the time of outbreaks is more likely to result in successfully raising funds. However these assumptions are not explicitly mentioned in the PB.

- *The narrative in the proposed PB 2014-15 provides relatively little in-depth rationale, assumptions, risks and contingencies for the re-allocation of resources, particularly how the WHO will become more cost-effective with less resources or how it intends to leverage the work of other players in the field to contribute to its set health outcomes. This has been underlined by some global health experts interviewed as well as donors. This finding is also echoed by staff. Whilst 62% of staff surveyed agree that WHO sets clear priorities for its work, they are only 30% to agree that allocation of funds is transparent or to agree that there is more alignment between WHO priorities and how resources are allocated across the organisation. This is even more prominent with Directors (D1-D2) who are only 21% to agree that allocation of funds is transparent. Some of the budgetary shifts presented in Figure 3 next page which are not self-explanatory include:*
 - NCDs and Health Systems are still marginal compared to other areas. Although the budget allocated to NCDs has increased by 20%, it only represents 8% of the total WHO budget. Health systems represent now 13% of the budget.
 - As part of Category 2 on NCDs, it is unclear why the sub-area of disabilities and rehabilitation represents the largest jump, of 60% compared to 2012-13. While it is clearly an important topic to be addressed, the material shift in allocation of funds, relative to others, is not supported by a narrative;
 - There is consistent feedback from Member States that WHO has lacked a systematic focus on well-being and the social determinants of health, including gender violence and socio-economic factors. While there has been an increase of 7% in this budget category compared to 2013-14, it is unclear what WHO's concrete deliverables will be, given that the outcome indicators relate to the monitoring of 'net

¹⁵ The Global Fund Annual Report, 2012.

primary education enrolment rate’ and the ‘number of slum dwellers with significant improvement in their living conditions’.

- The budget for ageing and health has also jumped by 125% compared to 2012-13. While this budget, is relatively marginal (9 million USD), the increase is significant and not backed by a supporting rationale.
- Category 6 (corporate services/enabling functions) is meant to decrease throughout the duration of the GPW. The PB 2014-15, however, contains a 10% increase. We do not understand which reform initiative will result in such a drastic reduction of A&M costs to fall below 2014-15 levels by 2019.
- *The funding for the programme still relies largely (77%) on voluntary contributions: voluntary contributions are anticipated to increase slightly (+1.1%) whilst Member States contributions remain stable for the 28th straight year. The PB does not address this imbalance.*

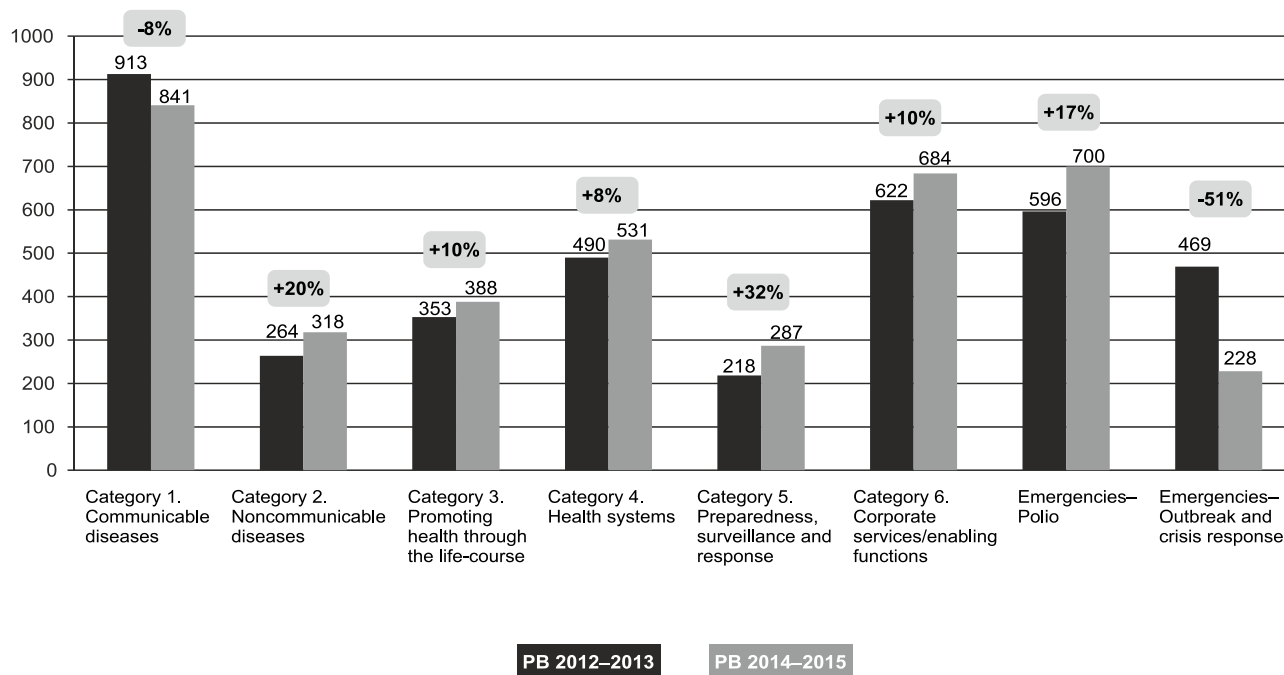
The impact is that ultimately, the WHO is not aligned with the growing needs of Member States and that there is a risk that country offices are not equipped with the tools and guidance to implement the appropriate policies in growing areas of work such as NCDs and health systems strengthening.

⇒ *A more robust use of national and disease burden data, dynamics of disease, capacity of national health systems, among other factors, and a clear demonstration of alignment against the leadership priorities of the WHO should form the basis of the PB 2016-17.*

⇒ *With such a constrained budget it will prove challenging for WHO to demonstrate impact against the priorities set out in the GPW and to deliver on its core mandate. Refer to section 9.1.1 for the related recommendation.*

Figure 3. PB 2012-13 and 2014-15 comparison against Categories of work

PB 2012–2013 and 2014–2015 comparison against categories of work



4.2.3. Operational planning 2014-2015

Although not an output as such of this reform outcome, operational planning is the natural extension and expression of the PB. In July 2013, GMG/PRP launched the operational planning process across the three levels of the organisation- this was accompanied with the issuance of a Guidance Note on Operational Planning to all Budget Centres, namely HQ Departments, regional divisions and country offices.

Guidelines¹⁶ were also circulated by GMG/PRP in August 2013 to Business Owners of the Reform and Directors to ensure reform-specific products and services were identified and included within 2014-15 biennial operational plans, to ensure the adequate funding. Operational planning workshops took place in regions, at varying levels, and support from regional offices was mobilised to guide and accompany country offices in the process.

As with the process used for GPW and PB, we noted some challenges to balance inclusiveness and timeliness. The process for incorporating regional and country level feedback was not fully defined in the operational planning guidelines, creating some uncertainty on the review process and need for additional interactions with MoH or Member States. Given the newness of the process, increased discussions with the DPMs and DAFs on the instructions, guidelines and process could have strengthened the level of engagement with regions and countries alike. Concerns were raised in some interviews with Member States, WRs and regional offices regarding the timelines given to regional offices to prepare for the planning process and mobilise country offices, although this feedback was not unanimous. Likewise, some country offices interviewed have noted the limited time available to adequately engage with Ministries of Health to define country needs and priorities for appropriate alignment of the 2014-2015 operational planning with CCS and national planning cycles.

There are also indications from CCS and interviews that a number of countries are placing more emphasis on some priority health areas such as health systems strengthening and NCDs than reflected in the PB and in country budgetary allocations. Several countries have pointed out to the lack of flexibility in funding re-allocations in the operational planning, within the budget ceilings provided by the PB 2014-15, and across health issues.

The Secretariat has acknowledged the need to improve bottom-up planning in the next operational planning process 2016-17 and is currently addressing this aspect through the Taskforce on operational planning 2016-17.

⇒ *Overall the approach and moderate shifts achieved in the programmatic reform are illustrative of the Secretariat's drive to reform but also of the challenges the Secretariat is finding in balancing speed, consultation and consensus by Member States. Refer to section 9.3.5 for the related recommendation.*

¹⁶ Guidance Note, Operational Planning 2014-15 for Reform, Identification and inclusion of reform-specific products/services within 2014-15 operational plans, August 2013.

5. Governance reform

5.1. Background

The governance structure of WHO is unique. The organisation is governed by the World Health Assembly, its decision-making body composed of the delegation of 194 Member States. This body determines the policies of the organisation, appoints the DG, approves the GPW and PB and passes resolutions. The responsibility to execute the policy decision of the assembly pertains to the Executive Board, composed of 34 members, which advises the WHA and reports on the execution of the resolutions passed at the WHA. The WHA meets yearly in May, while the EB meets bi-annually in January and in May (in a shorter meeting following the WHA).

In addition to this global governance structure, all Member States fall into one of the six Regional Committees (RCs), which act as the governing bodies for their respective regions. The role of the RCs is to set the policies for their regions. The RCs meet once a year during the months of September and October.

Since the inception of RCs, the first being the Directing Council of the Pan American Sanitary Bureau (PASB) in 1949, WHO has been challenged by the need to align Regional Offices (ROs) with HQ. In 1976, the WHA already alerted that ‘the Organization must never become a federation of six distinct regions with some vague entity at the central level as that would spell the end of WHO’¹⁷. Historically, the question of alignment between governing bodies has therefore been of key importance.

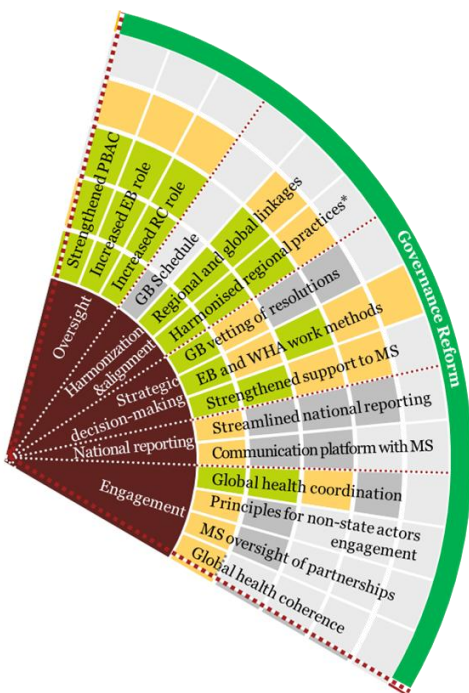
In line with this, the governance reform focuses on increasing transparency in governing body processes and alignment between the global and regional levels. It encompasses five major areas of work:

- *Strengthening the oversight function of WHO governing bodies at global and regional levels, including enhancing strategic oversight of the programmatic and financial aspects of the Organization through a strengthened PBAC and increased reporting of regional committees to the Executive Board;*
- *Harmonising and aligning governance processes and ensuring the interconnectedness at all levels, by aligning RC rules of procedures on the selection process for Regional Directors (RD), the review of credentials of delegates and the participation of non-Member States observers to RCs;*
- *Simplifying the processes to achieve more efficient decision-making by governing bodies, including addressing agenda setting and the timing for the issuance of documentation to Member States;*
- *Improving and streamlining national reporting, to address the issue of coordination of reporting requests to Member States;*
- *Agreeing on a framework for the engagement of WHO with NGOs and the private sector, to address issues of conflict of interest.*

¹⁷ Chatham House, the Role of the World Health organization in the International system, quoted in World Health Organization, The Third Ten Years of the World Health organization 1968-1977.

This area of reform is where success is most dependent on the ability of Member States to adapt their individual and collective behaviours. The next section will provide an update on the status of implementation of the above five initiatives.

5.2. Status



Some progress has been made in this area of reform although mostly in the form of short-term structural improvements (e.g. revision of the selection process for RDs, reporting of RCs to the EB). However, overall this area of the reform is making slow progress, both in terms of internal governance mechanisms and on the topic of engagement with non-state actors and national reporting. This has serious implications on the ability of the organisation to be strategic and assert its relevance in global health governance. This will take more than a short-term and Secretariat centric approach to change.

The section below presents for each of the reform initiatives under governance, an overview of progress to date and challenges encountered.

5.2.1. Oversight

In terms of strengthening the oversight role and capabilities of the various governing bodies of WHO, the following can be highlighted:

- *The terms of reference for the PBAC have been revised and endorsed by the EB on 28 May 2012 to equip the Committee with greater oversight responsibilities and for it to play a more active role in the monitoring and evaluation of programmatic and financial implementation. It was proposed to the EB January 2013¹⁸ that the PBAC could assess the financial implications of resolutions, prior to presentation to the WHA. We note that currently, the budget implications of draft resolutions are prepared by the Secretariat but there is little evidence that these are taken into account in the way draft resolutions are treated. We also note that items discussed at PBAC meetings are discussed again by the EB. In this context it is unclear to the IET whether the strengthening of PBAC is actually resulting in improved oversight and more efficient handling of EB meetings.*
- *Reporting from the Chairs of the RCs to EB was first started in January 2013¹⁹. In line with WHA's decision in May 2012, Chairs of the RCs have been asked to offer a summary report of the RC's*

¹⁸ WHO, Streamlining of the work of the governing bodies and harmonization and alignment of the work of regional committees, Executive Board, 132nd session, 14 December 2012.

¹⁹ WHO, Report of the regional committees to the Executive Board, Executive Board, EB 132/4, 18 January 2013.

deliberations and adopted resolutions to the EB. This practice is demonstrating a willingness to increase transparency and two-way communication between global and regional level, and is also contributing to EB's ability to have greater oversight on the work of RCs. The IET notes that the content of reporting is uneven across RCs, and may not reflect the depth of discussions on specific topics such as the WHO reform.

- *Some RCs are moving towards increasing transparency and efficiency of their governance processes.* This is the case for the European region which has strengthened the role of its Standing Committee to the RC, where Member States are now playing a much stronger role in agenda-setting and preparing the RC. The African region Programme Subcommittee, a subsidiary organ of the RC, also revised its ToRs (in effect in Sept 2013) to expand its scope of work from preparatory work towards RC meetings to performing oversight functions, i.e. monitoring the implementation of RC resolutions, examining reports on the implementation of internal and external audit reports, and reports on staffing. Standing Committees are in place in all but one WHO region. WPRO does not have a Standing Committee to develop the Regional Committee agenda or to involve Member States effectively in the nomination of officers for the RC, EB and WHA. Also the records of the Western Pacific Regional Committee record the fact, not the content, of Member State interventions. The next step is harmonising these practices and applying lessons learned across the Organization.

⇒ *The structural changes underway in internal governance arrangements are tangible elements of a more coordinated approach to how the Organization works. Member States are in the process of learning how to work within this framework.*

⇒ *Aligning the governance arrangements in WPRO with what is now in place in other regions should be explored.*

5.2.2. Harmonisation and alignment

Procedures between global and regional governing bodies are progressively becoming more aligned in all regions:

- *The scheduling of governing body meetings has not changed.* As presented by the Secretariat²⁰ in January 2013, it highlighted challenges to the current scheduling of the governing body meetings, namely that 1) the PBAC meeting the week preceding the January EB does not allow for enough time for the EB to fully consider the PBAC recommendations; 2) reports to the January EB can only reflect situation up to September 2013, given the preparatory time and submission. The recommendation to shift the PBAC and EB meetings from January to February is still under discussion and is unlikely to resolve the issue. This is illustrative of the constraints on the governing bodies to limit their ability to act swiftly on decisions that could improve governance processes. More promising alternatives could be to insert one or two additional days between the two meetings, and to conduct PBAC meetings and subsequent activities in such a way to fast track the production of PBAC outputs.
- *WHA's decision to harmonise the nomination process for Regional Directors, the review of credentials, and participation of observers have been implemented by all RCs.* The nomination process of the RD in EMRO and SEARO, the last two remaining RCs to review their rules and procedures were revisited during the 2012 RCs. New amendments that provide greater transparency on the selection criteria of RDs have

²⁰ WHO, Streamlining of the work of the governing bodies and harmonization and alignment of the work of regional committees, Executive Board, 132nd session, 14 December 2012.

therefore been endorsed in all regions. The impact of these internal governance changes will be more visible in the coming years, notably in the next rounds of RD nominations, and have already started with the nomination of RD SEARO and RD WPRO in 2013. These new changes signal a beginning towards greater transparency and openness to dialogue with non- Member States, although only an initial step.

- *Our review of RC reports demonstrates that several global resolutions have been taken forward at the regional level.* This is the case for example of the Strategy and Plan of Action for Integrated Child Health in AMR, the European mental health action plan adapted on the basis of the global mental health action plan in EUR, and the efforts of several regions to align their regional strategies to the Action Plan for the Global Strategy for the Prevention and Control of NCDs and to the new global monitoring framework. As discussed in 5.2.1, the first wave of reporting from RC Chairs to the EB will enable better understanding of the status of translation of global discussions at regional level. At the same time however, Member States raised that there is not a systematic mechanism to integrate WHA global resolutions into the RC agenda-setting and no formal coordination to ensure their implementation at country-level, which is where it matters. There is also no formal reporting to the EB of those resolutions by Member States. We also note that RC reporting to the EB does not follow a blueprint or specific guidance issued by HQ. This does not allow to align reporting and content across regions, and to facilitate the monitoring of the translation of global resolutions at regional and country level. This is a challenge given the reform's objective for more coherence across the organisation.

⇒ *Structural changes conducive to increased linkages between regions and HQ and harmonisation of working practices between regions are now in place. They provide a starting point from which to build on and improve. This notably involves continuous drive to ensure WHA resolutions are consistently translated at regional and country level.*

5.2.3. Strategic decision-making

This reform initiative has been set-up to enhance the processes to support more effective strategic decision-making from Member States. Against each of the outputs for this initiative, we note that:

- *Limiting the number of resolutions passed is at the core of WHO's ability to prioritise.* Feedback from Member States interviewed is that the passing of resolutions could be done more strategically. The rules and procedures provide for a variety of ways in which draft resolutions can be presented to the EB and adopted by the WHA. The current process has shown that, either draft resolutions recommended by the EB are re-opened and amended during the WHA or new resolutions are presented by Member States, whether or not the EB had recommended to the WHA a draft resolution on the same item. This creates a burden on Member States to re-draft resolutions, poses a strain on the WHA's workload and a challenge of strategic and efficacy nature to reach consensus within shorter timelines. As a result, resolutions may not address WHO's core competencies and Member States may not have the chance to assess the budget implications of resolutions. Amendments to the rules and procedures of the EB were prepared²¹ by the Secretariat to limit the untimely submission and number of draft resolutions, notably where the PBAC would play a more active role in assessing the financial feasibility of adopting resolutions. The EB requested the Secretariat to elaborate its proposals in the overall context of the rules of procedure and to report again to the 134th EB

²¹ WHO, Streamlining of the work of the governing bodies and harmonization and alignment of the work of regional committees, Executive Board, 132nd session, 14 December 2012.

in January 2014. More joint work is required from Member States and the Secretariat to agree on guidelines and procedures that will resolve this issue.

- *Improvement on methods of work of the Board and WHA has seen some varying progress. Since 2012, traffic lights at the EB and WHA have been welcomed by Member States and the Secretariat to instil greater discipline in debates and reduce the length of statements of delegations. Apart from this relatively straight forward logistical change, this area has made relatively slow progress, notably in the following areas:*
 - *The EB has yet to agree on a set of criteria for selecting items that should be part of its provisional agenda. In May 2013, two options for the inclusion, exclusion or deferral of items on the provisional agenda of the EB (EB133/3) were presented²² to the EB with the goal to agree on a clarified process and criteria to guide the selection of agenda items. Member States asked for further work on Option 2 so that it could be approved and better prioritization could take place. The challenge here is ensuring the right balance of agenda items so that they can be discussed in depth. As an illustration, the number of agenda items to be reviewed by the EB increased 40% between 2003 and 2014, from approx. 45 to 63 and that of the PB nearly doubled between 2012 and 2013, largely because of the presence of reform-related agenda items²³. Considering that EB meetings range between 5 and 7 days, depending on non-PB or PB years, the average remains one report per hour per day. In January 2014, more than 60 agenda items are to be covered in 5 days only, reducing Member States' time for deliberations. This constrained timeframe does not allow for adequate deliberations and decision-making altogether. The number and complexity of issues to be discussed added to the late issuance of documentation is not conducive to empowering the PBAC and EB to fulfil their respective roles. There is an intrinsic tension between the sovereign right of Member States to pursue their policies and the need to have a realistic number of agenda items at governing bodies.*
 - *Documentation to the governing bodies has doubled over the past 5 years and continues to be made available to Member States in an untimely manner. The number of pages in documentation has gone from 347 pages at the EB-122nd session in 2008 to 775 at the EB-132nd session in 2013. This is closely linked to the fact that the number of agenda items has continued to grow over the years. On the other hand, Member States have highlighted that documentation tends to arrive in an untimely manner. Combined with the increase in documentation, the absorption capacity of Member States is challenged, particularly that of smaller delegations. Member States have suggested moving the period for submission from 6 to 3 weeks.*
 - *The amendments to the Rules and Procedures of the EB and governing bodies, presented in January 2013 (EB132/5 Add.3), to limit the late submission of draft resolutions and to limit the number of agenda items have yet to be finalised. New recommendations to the Rules and Procedures are expected to be presented at the EB session in January 2014 for endorsement. Addressing this governance issue is at the core of the ability of governing bodies to become more strategic in the way they address agenda items and manage resolutions.*

²² WHO, Governance: options for criteria for inclusion, exclusion or deferral of items on the provisional agenda of the Executive Board, Report of the Director-General, Executive Board, 133rd session, 8 May 2013.

²³ WHO, Review of EB agenda, 2010 and 2013.

- *Efforts have been engaged to facilitate Member States participation in governing bodies. Some new developments have happened to better brief Member States before governing body meetings and to make the reports more readily available. This includes the development of a handbook on procedural issues for EB Officers to be introduced in January 2014; a training planned in November 2013 for WRs to better prepare EB members prior to governing body meetings; focus on providing substance to the mission briefs; the integration of a web feed on the governing body website to be aware of newly available governing body documentation; and a quick response (QR) code to facilitate downloading reports at WHA meetings and a web feed to allow Member States to observe governing body meetings through webex.*

⇒ *The Organization has not resolved the intrinsic tension between the sovereign right of Member States to pursue their policies and the need to have a realistic number of agenda items at governing bodies. The ultimate result is, however, detrimental to all, including to those Member States exerting their sovereignty. This leads to: a lack of adequate time to prepare for governing body meetings, strategic items not being discussed in sufficient depth and decisions being postponed. Refer to section 9.1.2 for the related recommendation.*

5.2.4. Streamlined national reporting

Consultations on streamlining national reporting are at an early stage to refine the first set of options on streamlining national reporting presented to the EB in January 2013.

- *Proposals for streamlining national reporting were presented to the EB at its January 2013 session²⁴. Since then, consultations on streamlining national reporting have been organised, notably as we observed during the July 2013 DPM network meeting. The objective of this meeting was to engage the regional level in finding solutions to address a reporting that has become increasingly resource-intensive for Member States, given the rise in the number of requests for health data from different UN agencies, development agencies and donors. The issue at stake is the need for a better coordination and rationalisation of reporting requests to Member States, inside WHO and across the UN family.*
- *The Secretariat is considering merging and upgrading the various web application platforms (i.e. SharePoints) in use across the Organization in order to provide a communication platform for Member States and the Secretariat. This initiative is however at initial stages of discussion. We did not identify an attempt to co-design such a solution at the UN level, which would seem relevant given the pattern of Member States reporting, and similar demands on national authorities from other UN agencies addressing health and work underway at the UN High Level Committee on Management (UNHLCM) on data visualisation.*

⇒ *National reporting is in its early days and is testing on one hand, the Secretariat's ability to facilitate reporting coordination with the rest of the UN family on health matters and on the other, the Member States' willingness for greater transparency. Given the complexity of the matter, the need to tackle this challenge as a UN-wide challenge and the need to for WHO to prioritise reform initiatives, the priority given to this area in the reform could be lowered. Refer to section 9.2.2 for the related recommendation.*

²⁴ WHO, Options to streamline the reporting of and communication with Member States, EB132/5 Add.4, 18 January 2013.

5.2.5. Engagement of non-state actors

While WHO governing bodies have undergone some recent changes in the area of inclusiveness and transparency to non-state actors (e.g. the AFRO region saw the first presence of NGOs at its 2013 RC and the RD EURO invited the NGO representative for a separate session at the 2013 RC), this area of the reform has experienced a slow pace, compared to governance best practice, particularly in the areas of engagement with non-state actors and conflict of interest and strengthening WHO's role in global health. Specifically:

- WHO has been engaging on the global front to address international health issues.* Notably, this has been evidenced by WHO's contribution to the Busan Partnership for Effective Development (2011) and has provided technical advice to the IHP+²⁵ in the area of coordination of partners in the development of national health policies. The 2011 first global ministerial conference on healthy lifestyles and NCD control, co-hosted by WHO and the Russian Federation²⁶ was also seen as successful and demonstrated WHO's ability to exert its convening power in global health. In consultation with Member States, WHO plans to develop a global mechanism to coordinate the activities of stakeholders on NCDs, based on its newly launched Action Plan on NCDs 2013-2020. This will be an important test of its ability to assert leadership and coordination on NCDs. Finally, WHO is present on the post-2015 agenda discussions, where it led together with the governments of Botswana, Sweden and UNICEF between September 2012 and April 2013, the health thematic consultation of the UNDG post-2015 'global conversation'. Global health coordination is also key at country level. In this respect, Member States interviewed mentioned that the Secretariat has yet to fully play its role in supporting them to coordinate health players at local level. There were notably mentions that WHO country offices need to play an increased role in raising awareness of the global health leadership priorities set-out in the GPW and to align health players around those, in coherence with national health strategies and CCSs.
- Consultation with NGOs in preparation of governing body meetings could be more inclusive.* Interviews have shown that there is still a long way to go on matters of inclusiveness, especially when compared to organisations such as The Global Fund, GAVI and UNAIDS. For example, The Global Fund Board is composed of 20 voting members with equal rights, 5 of which are from the NGO community, foundations and the private sector. Civil society is represented on the GAVI Alliance Board. These are best practices as they ensure greater transparency, accountability and responsiveness of the respective organisation. At WHO, non-state actors have an observer status. At the global level, NGOs contributions are vetted by the Secretariat and presented at the end of governing body meetings, when Member States have completed their discussions and debates. Further, NGO lobbying and their ability to actively participate in discussions is highly dependent on the NGOs capacity to do so. Interviews with NGOs and Member States have raised that smaller local and grassroots NGOs are under-represented in the global and regional dialogue and that the limited timing of invitations does not allow for appropriate preparation. The option of setting-up a Committee C²⁷, a separate WHA committee that would offer non-state actors an opportunity to consolidate and coordinate their input to reinforce accountabilities between WHO and other stakeholders, has not gained unanimity. However, discussions should continue to explore transparent ways of engaging a broader base of non-state actors. As of now, Member States funding represents one half²⁸ of WHO's total voluntary

²⁵ IHP+, Progress in the International Health Partnership & Related Initiatives (IHP+), 2012 Annual Performance Report.

²⁶ <http://www.who.int/bulletin/volumes/89/7/11-089292/en/>; <http://www.un.org/en/ga/president/65/issues/ncdiseases.shtml>

²⁷ Ilona Kickbusch, Wolfgang Hein, and Gaudenz Silberschmidt, Addressing Global Health Governance Challenges through a New Mechanism: The Proposal for a Committee C of the World Health Assembly, Journal of law, medicine & ethics, 2010.

²⁸ WHO, WHO's Financing Dialogue, Mission briefings, IEOAC, 16 October 2013.

funding. The IET considers that in the long run the opening of WHO to civil society is vital if WHO is to retain its relevance and support.

- *On the topic of engagement with non-state actors, discussions have been slow at the global level in defining a policy for engagement with non-state actors.* Despite repeated consultations and attempts to reconcile governing body approaches, the draft policy paper on WHO engagement with NGOs, prepared for consideration at the 132nd session of the EB, did not find consensus among Member States. A Special Envoy on NGOs was appointed by the DG in 2013 to guide and facilitate the negotiations- this has been seen as an extremely positive step by Member States and NGOs alike. A consultation on the topic took place on 17-18 October 2013 in preparation for the 134th EB session in January 2014, when a revised draft policy will be presented for adoption. At the core of this policy is the need for WHO to put in place adequate safeguards, including a robust conflict of interest and transparency policy, to enable further interaction with non-state actors. We note, however, that work with non-state actors has been better managed in some regions and WHO Departments than in others:
 - *At the regional level, PAHO is a region that has implemented effective mechanisms with the private sector.* In 2011²⁹, PAHO invited governments, academia, civil society and private sector to participate in the Pan American Forum for Action on Non-Communicable Diseases (the Forum). The Forum was regulated by rules of member engagement, which provided a framework for managing conflict of interest (i.e. exclusion of certain industries with commercial interests and diversification) and ensuring commitment (i.e. signed shared value statement). This has been seen as a step forward towards a multilateral approach to dealing with NCDs.
 - *At a programmatic level, the Polio Eradication program has been successful at engaging non-state actors,* notably NGOs and the private sector in the development of multi-year action plans for polio and in the planning of financial resources for the programme. NGOs and private sector entities are fully involved in the Global Polio Management Team Plus (GPMT+). This forum is composed of WHO regional offices and HQ polio staff, team leaders from priority countries, partners and core donors, and meets bi-annually to discuss strategic planning, technical direction, management and resource planning and allocation.
- *Member States involvement and oversight over WHO hosted partnerships has made some headway with the presentation of the report on WHO's hosting arrangements³⁰ at the EB January 2013 session for consideration.* The paper offers a presentation of the contributions and also challenges encountered with hosted partnerships, on the programmatic, governance and financial fronts. These were not endorsed and are under discussion. Notably, there is a current disconnect between the governance structure of WHO governing bodies and its hosted partnerships, and an inability for WHO governing bodies to exercise their oversight role. Since then, work is underway to develop a framework for review of hosted partnerships to be presented to the 134th EB, with a first review conducted in 2014. An important next step will be to agree on standard hosting arrangements with partnerships, for which consultations will be essential.
- *The role WHO should hold in the global health architecture has not been discussed in details by Member States and the Secretariat alike.* Over the last twenty years, WHO's authority and access to funding for its programs has been challenged by the emergence of innovative and specialised global health players, that have gained increasing legitimacy in technical assistance in developing countries. There are concerns from academia and partners that WHO has been weakened with the expansion of global health initiatives, in

²⁹ http://www.paho.org/hq/index.php?option=com_content&view=article&id=7344&Itemid=1926

³⁰ WHO, WHO's arrangements for hosting health partnerships and proposals for harmonizing WHO's work with hosted partnerships, Report by the Director-General, Executive Board, 132nd session, 23 November 2012.

what has been called ‘the golden era of global health’³¹. Interviews have shown that although WHO is seen as a critical player, and that its intergovernmental nature is valued, it has not addressed with enough vigour the question of its role in global health governance. There is a feeling that WHO is ‘*tip-toeing around the essence of the organisation*’, as presented by a global health advisor interviewed. In line with this, it appears that the paper³² on WHO’s role in the global health governance presented at the EB January 2013 was not discussed in length, nor was the question of balance between the normative vs technical role of WHO in a post-2015 agenda. The proposition to establish a Global Health Forum- a convening platform of global health actors steered by WHO with the goal of coordinating actions and addressing emerging health problems- did not find agreement amongst Member States and was not seen as the adequate platform for discussing the role of WHO. Other platforms have to be found to address this issue in depth.

- ⇒ *WHO is making marginal progress in addressing the goal of greater coherence in global health. There are indications that the revised internal governance arrangements will not be enough to modify Member States individual and collective behaviours towards efficient and strategic decision making. Overall the Organization has yet to tackle the question of how the Organization opens up to the outside world. Refer to section 9.2.2 and 9.3.5 for the related recommendation.*
- ⇒ *One option would be to enhance or renew the mandate of the H8, an informal meeting of the leaders of WHO, UNICEF, UNFPA, UNAIDS, GFATM, GAVI, Bill & Melinda Gates Foundation and the World Bank, and position WHO to be the coordinating function for this group. This would require that this role is explicitly recognised by the group members and resourced within WHO. Also the pros and cons of giving a more formal mandate should also be carefully weighted, given that the strength of this meeting also lies in its informal nature.*

³¹ Morrison JS. The end of the golden era of global health ? Center for Strategic and International Studies; 17 April 2012. Available from URL: <http://csis.org/publication/end-golden-era-global-health>.

³² WHO, WHO’s role in global health governance, Report by the Director-General, Executive Board, 132nd session 18 January 2013.

6. Managerial reform

6.1. Background

The need to address its financial model is at the core of the WHO reform launched by the DG in 2010. Over the years the WHO has been operationally constrained, because of its high dependency on earmarked and unpredictable funding. The issues can be summarised as follows:

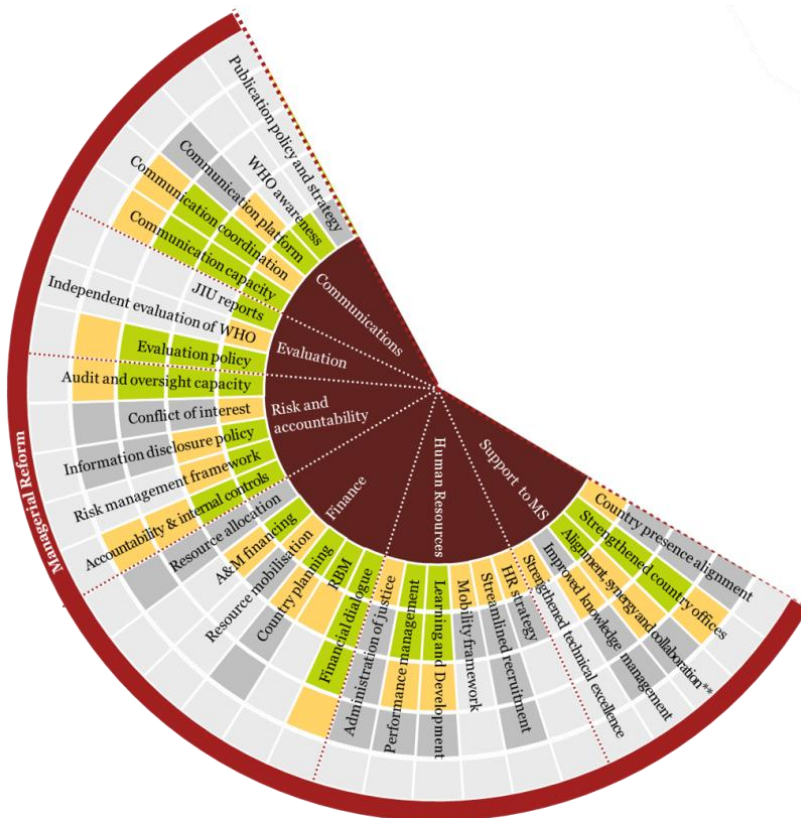
- *Misalignment and flexibility.* Funding has not been consistently aligned to PB and WHO's priorities, as a result in part to a high reliance on VCs which correspond to 77% of the approved 2014-15 PB, compared to 23% for ACs. Donors have increasingly earmarked their VCs. This has resulted for WHO in a lack of ability to direct funding to areas of highest need.
- *Predictability.* At the beginning of the biennium, the organisation is only funded to a level of 50% of its functions, mainly because of the unpredictability of VCs.
- *Dependency.* The WHO is reliant on twenty major contributors including a few non-state actors and there is a need to broaden the donor base so that burden sharing is carried by all Member States.

From the discussion on the financing model, has also emerged the need for WHO to improve its administrative procedures, revamping its HR management and putting in place the mechanisms for a more results-oriented and accountable organisation. In line with this, the managerial reform encompasses six major areas of work:

- *Improving the technical and policy support to Member States*, through a better definition of roles and responsibilities across the organisation and with an emphasis on country support;
- *Addressing outdated HR organisational policies*, and setting-up recruitment and mobility processes that can target the most appropriate workforce for WHO;
- *Defining a stable financial model that works for WHO (as explained above)*, supported by a stronger resource-mobilisation, planning and resource allocation function;
- *Strengthening accountability for results and resources*, and being able to demonstrate impact;
- *Strengthening the culture of evaluation*, and the use of evaluation results to improve service delivery at all levels of the organisation;
- *Giving a strategic focus to the communication function of WHO*, by consolidating and strengthening the WHO internal capacity and leveraging technology platform to increase WHO's visibility.

This reform area is broad and dependent on the Secretariat's identification of the right tools and policies to be implemented, as well as the need for interconnectedness between the various initiatives.

6.2. Status



Reform initiatives under the Managerial reform have been moving at different paces. The outputs most advanced include: the Financing Dialogue and its web-portal are in piloting phase; the capacity of the communication function is being strengthened; progress has been made in developing an internal control framework and rolling-out a management Dashboard; and WRs have been attending a well-received training on ‘Global Health Diplomacy’ to address the growing needs of Member States in this area.

On the other hand, challenges in the area of HR management remain largely unresolved. Getting the right staff, at the right place at the right time will be essential for WHO to achieve its ambitions of strengthening overall efficiency and performance of the organisation.

6.2.1. Support to Member States

Support to Member States encompasses a broad range of outputs and deliverables, with a focus on strengthening the coordination and quality of services delivered to Member States. In line with this, the following headways have been made:

- Efforts are underway to better align WHO presence to country needs and priorities, although this varies between countries and regions:
 - *A number of country offices have greater focus through the recent renewal of their Country Cooperation Strategies (CCS), enabling them to tailor and align WHO support to national needs. A challenge raised by WRs has been the fragmentation (through small cash transfers) and the non-strategic nature of service delivery to Ministries of Health. For country offices, a well-crafted CCS has proved to be a useful tool to address this and define the parameters and focus of engagement with Member States. The process of renewal of CCS has enabled WRs to hold a strategic dialogue with MoH on those areas of support where WHO can add the greatest value for money. For example, the Thailand CCS saw a reduction in its strategic areas, from 7 large encompassing health challenges in 2008-2011³³*

³³ WHO, WHO Country Cooperation Strategy 2008-2011, Thailand.

(e.g. health systems, communicable diseases, human resources for health (HRH)) linked to 13 strategic objectives, to 5 more focused health priorities in 2012-2016³⁴ (e.g. community health system, networking for NCDs, road safety) linked to 10 strategic objectives. For Thailand, the goal was to reduce the number of major results (i.e. 200) which were thinly spread across 13 strategic objectives. Also, feedback from Member States and WRs indicates that priorities of the CCS or operational planning discussion do not necessarily align with the budget allocation defined in the PB. The limited flexibility of budget ceilings allocated to regional and country offices is a constraint that will only be addressed in the 2016-17 budget process, with the move towards a bottom-up approach to planning.

- *Work has started at regional and country levels to align their operational structure to the new CCS and Category Networks and to identify the best staff available.* Category Networks encompass the Programme Areas that feed into the outcomes defined in the six categories of the 2014-2015 Programme Budget, and replace the networks previously established (i.e. the Strategic Objective Networks). All regions have embarked, at various levels, on a re-profiling exercise of regional and country staff and position descriptions are being updated against the functions of work produced by the taskforce on the three levels of the organisation (see below). AFRO has re-structured to align its units to the Category Networks, merging services as required for greater coherence. In EMRO, HR adjustments are taking place alongside the operational planning process. In WPR, high calibre technical advisors are being sought to fill key positions. Whilst the CCS offers a blue-print to re-align country processes and support and despite positive comments received by Member States, there were also mentions that the realignment of WHO's delivery model to meet the needs has yet to fully materialise in the form of strengthened expertise of the country office or in how WHO is organising itself to address issues best addressed at sub-regional level (i.e. cross border health issues, migration). In line with this, the staff survey shows that globally, 41% of staff believe regional and country offices are not adequately staffed. This is even more prominent in EUR (79%), with the highest number of countries in a WHO region.

⇒ *Through the CCS and operational planning, the Organization has the tools to initiate the realignment of its services and delivery model to Member States' needs.*

⇒ *The realignment needs to move ahead with a concrete shift in staffing, delivery models and skillsets, and accelerate bottom-up planning in 2016-17. Refer to section 9.2.2 for the related recommendation.*

- *The initiative focuses on the selection and development of WRs.* This initiative is now completed, with the implementation of a roster of qualified candidates and the training of WRs on global health diplomacy. Feedback from this course offered to WRs since 2011 have been extremely positive. The IET noted that the enhancement of technical capacity has, however, been largely focused on the WRs rather than on strengthening the overall capacities of country-level staff. A challenge for WHO will be to address the balance in staffing needs and the core competencies required (i.e. the issue of high degree of technical specialisation of and changing country needs). Member States have expressed the need for WHO to move away from programme design towards more of policy and advisory support. This shift needs to be coupled with high calibre staff that can effectively represent WHO and give credibility to the Organization. This has an impact on the location of its staff (e.g. country vs. regional or sub-regional offices) and contract types (e.g. NPO vs. IP staff).

³⁴ WHO, WHO Country Cooperation Strategy 2012-2016, Thailand.

Headway has been made in clarifying roles and responsibilities of the different levels of the organisation, but also of the various networks, for more organisational coherence:

- *Solid progress has been made in defining the roles and responsibilities at the three levels of the organisation³⁵. This work has been spearheaded by the ‘Taskforce on the roles and functions of the three levels of WHO’, and articulates the roles for each of the three levels based on the six core functions of the 12th GPW, starting from where WHO wants to make a difference at the country level through the regional offices and up to HQ. This work has fed into the development of the PB 2014-15 to inform the key deliverables for each programme area, creating the accountability framework against which the organisation will be measured. While the re-definition has happened at a strategic level, this has yet to permeate throughout the Organization. From our survey, 51% of D/P/NPOs believe that they have clarity on the breakdown of responsibilities between HQ, regions and country level, compared to 57% in the JIU survey.*
- *Work is underway to institutionalise the Category Networks and accountability framework between the various decision-making groups and networks at the Secretariat (i.e. GPG, ADG, DPM network, DAF network, technical networks). The GPG commissioned in May 2013 the development of a study on strengthening and institutionalising the roles and responsibilities of the Category Networks set up to manage and oversee the work within each of the six categories of work in the PB 2014-15. The study is expected to be finalised by end January 2014 with the aim to 1) clarify the overall coordination of the Category Networks, 2) develop standard operating procedures and a code of conduct for the operations of the Category Networks and 3) define a mechanism for the effective monitoring and oversight of the work of the Category Networks. This new framework should improve the fluidity of reporting, communication and coordination. At present, in relation to coordination within levels of the organisation, results are low in absolute terms- 22%, 25% and 31% of staff believe it is sufficient at HQ, regional and country level respectively. Most prominent is that 55% of staff at HQ believe coordination is lacking. Attention to this area is key as the ability to work across functional silos is key for the implementation and sustaining of reform.*
- *Strengthening country support units at HQ and regional levels has been uneven. The new set-up of CSU at the level of Regional Offices is benefiting some country offices, when requiring technical expertise, in establishing basic agreements between WHO and Member States, in the development of grant proposals and in coordinating assistance to country offices. The practice is, however, in pilot phase and would benefit being rolled-out to a larger number of countries and structured as a delivery model. Although not referenced to in the HLIP, the WHO Country Focus Strategy is being revisited and will be presented at the WR meeting in November 2013 for consultation. In terms of inter-level coordination, 27% of staff thinks the coordination between HQ and regional offices is sufficient, while this figure increases to 36% on the coordination between regional and country offices. The lowest score refers to HQ and country level coordination, where only 21% of staff think it is up to standards.*

⇒ *WHO now has a blue-print for the delivery and coordination of its services, through the definition of the responsibilities at the three levels of the organisation. Communicating this split of responsibilities to Member States will facilitate efficient and effective interactions with the Organization.*

³⁵ WHO, ‘The Overarching Roles and Functions of the Three Levels of the Organization’, presented and discussed at the Global Policy Group Retreat, March 2013.

- *Management consider that information management is weak at WHO.* Although progress has been made with the launch of an external portal for WHO documentation, a policy on information management is not yet in place (planned for 2014). The aims and scope of knowledge management are not clear to 60% of staff, indicating room for improvement. In May 2013, a public platform on the WHO website was launched to offer a one stop shop for all WHO documentation, including resolutions and articles. Next steps include the population of the platform and the digitalisation of the documentation and its tagging, with a timeline of December 2015. Efforts need to focus on defining WHO's strategic direction on Knowledge Management, streamlining its systems and processes and clarifying its roles and responsibilities.
- *A taskforce on technical excellence, co-chaired by an ADG and RD, has been set-up but needs to be reinvigorated.* With the objectives to strengthen the technical capacity of WHO advisory bodies and also to ensure that the pool of consultants providing support to Member States is adequate and supported by an up to date and relevant database. In line with this, WHO wishes to strengthen its collaboration with national stakeholders such as academia and research centres to increase national capacity around data collection and health information systems and raise it to WHO's standard. A draft document was circulated. However, the taskforce has not been active and there is acknowledgment from Management that this area should be given greater attention. Moreover, this piece of work will need to be closely aligned to the HR recruitment policy and global pooling of consultants.

⇒ *The thinking and design of strengthened support for Member States have made some progress but concrete achievements have been limited to date. 2014-15 will test management's ability to execute against this vision, in an area that has a far reaching impact on WHO staff and Member States alike. Refer to sections 9.2 and 9.3 for related recommendations.*

6.2.2. Human resources

In its May 2013 report³⁶ to the WHA, the PBAC noted that it ‘remained concerned that the Department of Human Resources Management (HRD) was not appropriately structured or resourced to respond to the heavy demands placed on it by the many initiatives now under way in the organization.’ Human resource reform equates for many to the reduction in staffing (19.3% in HQ and 11.5% in the AFRO region³⁷) that the organisation has gone through in 2010-11 in the wake of the financial crisis. Besides this restructuring triggered by external factors, the HR reform has made slow progress, partly due to a transition in HR leadership. In substance:

- *The HR strategy is under development, a draft of which will be presented to the GPG in November 2013 for adoption in 2014.* While the HR strategy strives for a flexible and mobile workforce, a high-performing culture and enhanced staff learning and development, there are serious concerns that the HR procedures to date have not been enabling the performance of the WHO.
- *Progress has been slow in the reform of recruitment.* A global recruitment policy is under development with a delivery date planned for end 2013. Data from the ‘HR annual report’ shows that on average the time for selecting new staff, from initial advertisement to decision, has improved from 5.9 to 4.2 months from 2010 in 2012. Similarly, we note a slight improvement in the perception staff have of the fairness and transparency of recruitment procedures globally, according to D/P/NPO staff, from 21% (JIU) to 30%. However, there continues to be a strong feeling of unfairness and only 30% of staff think that recruitment processes at WHO are fair or transparent, and this figure falls at HQ (23%). The new global recruitment policy aims to align practices across the organisation, a big challenge given that regions have different recruitment procedures, panel compositions and selection criteria. This policy should lay the foundations for addressing gender imbalance which is a challenge in some regions (e.g. none of the new appointed P staff in the AFRO region between 1st January and 31st December 2012 were female, compared to 72.7% in the EURO region for the same year and staff category).
- *Interviews have demonstrated that there is a lack of guidance and direction on mobility at the global level.* In 2009, WPRO engaged in a staff consultation to articulate its vision for the future and define a comprehensive mobility framework³⁸. According to the staff we interviewed in the WPRO region, the mobility scheme has opened the dialogue between staff and managers who had never had a discussion on their career aspirations. Based on this achievement HQ embarked, in July 2013, on the process of developing a global level mobility strategy. As highlighted by a global survey in WHO (late 2012) on attitudes to mobility, increased mobility within WHO is seen as essential. In 2012, 61% of international staff throughout WHO wanted to see increased movement within regions and HQ and 66% favoured increased movement between regions and HQ.³⁹ This is in alignment with our survey results which indicate that globally, 50% of professional staff (international and national) think they will move to another duty station in the next three years. The organization however currently lacks an enabling framework for mobility, notably a clear HR strategy, incentive system and approach to career planning.

⇒ *The survey shows that the staff acceptance of mobility is improving.*

³⁶ WHO, Human Resource Annual Report, Report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-sixth World Health Assembly, A66/60, 20 May 2013.

³⁷ WHO, Human resources: annual report, Report by the Secretariat, 66th WHA, 14 May 2013.

³⁸ WHO WPRO, Moving Forward, Making a difference’

³⁹ WPRO, Mobility Scheme report

The following outputs are considered activities and building blocks within the implementation of the HR strategy and are commented as follows:

- A global e-learning platform is planned to be launched before the end of 2013. Currently, 36% of staff globally believes that the training received is adapted to their career development needs (survey results). Feedback is even more positive in the AFRO, WPRO and SEARO regions.
- An enhanced PMDS tool will be launched in Jan 2014. Globally, 36% of staff that that their training is linked to their individual performance appraisal system in line with WHO priorities. These figures have remained stable compared to the JIU survey. A booklet on core competencies was developed in Feb/March 2013, 'Putting competencies into practice'. A guide for effective performance assessment including norms for objective setting and evaluation was under preparation at the time of our evaluation. 21% of D/P/NPO staff who responded to our survey think the system of administration of justice in WHO ensures an adequate and fair treatment of staff complaints, compared to 23% for JIU.

⇒ *The results of the staff survey show the major challenge the Secretariat has to become an employer of choice and build a trusted relationship with its employees. This is all the more fundamental given the significant headcount reduction that took place in 2010-11 and the fact that some HR initiatives to date have been rather reactive or primarily driven by financial concerns. The Organization has had to date a rather piecemeal approach to reforming HR and currently lacks an HR vision that would be attractive to talent, at a time when WHO needs to remain attractive to the best technical specialists. The finalisation of the HR strategy will be critical to address this matter. Refer to section 9.2 for the related recommendation.*

6.2.3. Finance

Defining a financing model for WHO that ensures flexibility, transparency and the allocation of resources in alignment with priorities is at the core of the WHO reform. This initiative is at the core of reform and contains 6 outputs and 16 deliverables. In line with this focus, the Secretariat has mobilised in this direction, as follows:

- The Financing Dialogue of June 2013 is well on track and there is general praise for WHO's commitment to transparency.* In particular, the presentation of the web-portal on financial data in June, which is under piloting at the time of this evaluation, was welcomed by Member States as a tool that will provide an increased level of transparency and real time data on financial contributions. The Member States interviewed during the June 2013 session informed us that for them, the concern is making sure that the new financing model is conducive to a better alignment of donor funding to the priorities of the PB 2014-15. Additionally, feedback from stakeholders on the planning process of the Financing Dialogue is that it was not structured around a sound project management approach. Further, ownership of the initiative within the Secretariat was not clearly delineated. The identification of dependencies of the finance-related initiatives defined in the reform agenda (i.e. financing dialogue, resource mobilisation and A&M cost recovery options) have also not been fleshed out. We have described the results-based planning and budgeting mechanism in section 4.2.1 above. As highlighted, the new results-chain for defining accountability for results for the organization is welcomed, although it has some limitations, notably the robustness of the theory of change.
- Slow progress has been made on coordinating resource mobilisation efforts across the three levels of the organisation.* The DG set-up in 2012 the taskforce on resource mobilisation and management strategies, co-chaired by the DDG and RD EURO, with the mandate to professionalise RM. The taskforce presented its draft report to the GPG in May 2013.⁴⁰ There is consistent feedback from interviews that WHO is not giving enough attention to coherence in resource mobilisation and that its performance could be improved. Comments were made by donors contrasting the sophistication of Global Fund's resource mobilisation and advocacy practices with WHO's rather organic approach. Only 19% of respondents to the staff survey agreed or strongly agreed that there is adequate coordination in resource mobilisation activities across the organisation. Only 23% agreed or strongly agreed that they conduct resource mobilisation activities (if any) as part of a coordinated whole of WHO approach. As a consequence, we noted a degree of unease with the regions and country offices we spoke to, as there is uncertainty regarding their future ability to leverage resources from local donors. The upcoming Financing Dialogue in November 2013 is only one step in addressing the challenges of WHO financing and harmonisation of resource mobilisations practices.
- A study of A&M costs and financing was presented to the PBAC in January 2013.* The Secretariat is implementing some short term recommendations and defining a new cost categorisation and recovery model. The question of the sustainable financing of category 6 (corporate services/enabling functions) is far from being resolved. It is most unlikely that donors will accept to fund this category, except for specific initiatives such as the reform. Other sustainable mechanisms therefore need to be implemented. Also changing Member States, donors and internal staff awareness and behaviours requires a skilled change management approach and expertise whilst the topic to date has been mostly treated as an accounting issue.

⁴⁰ WHO, Final report of the Task Force on Resource Mobilization and Management Strategies, May 2013.

- *On matters of resource allocation, our survey results indicate that only one third of staff consider resources not to be transparently allocated or aligned with WHO priorities.* In its draft paper⁴¹ to the GPG in May 2013, the taskforce on resource mobilisation established the key corporate principles for transparent allocation of funds.

⇒ *The willingness of Member States to address WHO's financial health will be a reflection of their confidence in the Organization. It is strongly linked to WHO's ability going forward to demonstrate greater administrative robustness and accountability for results. Refer to section 9.1.1 for the related recommendation.*

6.2.4. Accountability and transparency

Improving accountability for results is at the core of WHO's endeavour to reform. The introduction of GSM, as discussed in JIU's 2012 report, has 'contributed to an ongoing change process from a bureaucratic to a more business-oriented management culture in WHO'. The reform follows in those tracks to modernise and update business processes and procedures at WHO:

- *A framework for internal controls has been designed, with the core building blocks in place for roll-out.* The policy framework lays out the core components of the internal control framework, roles and responsibilities across the organisation and the governance structure to oversee the effective implementation of the internal control framework. The GMG is responsible for leading this piece of work, validated in July 2013 and is now embarking on the construct phase. In addition, over a hundred of Standard Operating Procedures (SOPs) have been updated, reviewed and those that apply to staff have been made available through an e-manual for utilisation (e.g. travels, procurement). While staff have been informed, no formal training has taken place on the SOPs. A challenge for this reform initiative will be the need to integrate internal controls and risk management frameworks, as part of the overall accountability framework. Another challenge will be to design the supporting processes and automation needed for successful implementation, namely to develop the guide to help managers apply the day-to-day operations of internal controls, define the delegation of authority and ensure that relevant staff and Directors are trained on the framework and its application. The IET would like to note that significant upfront financial, technical and human resources are necessary for the success of ERM and should be considered in the piloting phase for organisation-wide integration.
- *The performance and compliance Dashboard was implemented in July 2013.* The tool displays managerial/administrative metrics and displays them in a dashboard format. The dashboard is an important step towards a change of culture in reinforcing accountabilities across the organisation and will be enhanced progressively. The dashboard is available to all managers to consult and review the status of 11 KPIs. Access has been granted extensively, but no guidelines on accountability or mechanism for follow-up on actions taken based on the dashboard results have been set-up to date.
- *On risk management, a framework and preliminary corporate risk register were defined and endorsed at the 133rd session of the EB in May 2013⁴².* Despite these two deliverables being completed, much remains to be done to operationalise risk management and turn it into a way of doing business and a management

⁴¹ WHO, Final report of the Task Force on Resource Mobilization and Management Strategies, May 2013.

⁴² WHO, Corporate risk register, Organization-wide strategic risk management in WHO, Report by the Secretariat, Executive Board, 133rd Session, 17 May 2013

tool. Whilst the establishment of a Compliance, risk management and ethics Department is a step in that direction, the HLIP is silent on next steps. PAHO has already established a risk management framework according to ISO31000 and as advised by GPG, the experience and lessons learned should be carefully reviewed and utilised to avoid duplication and parallel functions. Refer to section 9.2.1 for the related recommendation.

- *The information disclosure policy is under consultation and revision.* The impact of this policy on processes has yet to be assessed however, prior to it being presented to Member States.
- *The management of conflict of interest will be the responsibility of the newly appointed Compliance, Risk management and Ethics Department.* The revision of the declaration of interest policy has not yet started, and is behind schedule. The establishment of such a policy is strongly tied to the development of a framework for managing conflict of interest in WHO's engagement with non-state actors.
- *An accountability compact between the DG and ADGs is under development and sets the roles and functions, expected standards in each of the key competencies and behaviours and metrics for management.* This is based on a compact introduced by the UN Secretary-General and will be launched in January of 2014. The compact will help clarify the role of ADGs and their relationship to the DG. The definition of this compact is an opportunity to ensure that transversal ways of working across areas and geographies are promoted. It is also an opportunity to ensure accountability for the success of reform are formally documented.
- *The capacity and oversight has also been increased at the Secretariat level with the recruitment of staff at IOS in HQ to expand audit coverage across the organisation and support partnerships (e.g. UNAIDS, Stop TB, RBM).* Additionally, ROs and country offices noted that the management of internal review and assessment missions (IRAM) have supported the offices to identify bottlenecks to administrative performance.

⇒ *Major steps in defining a governance, risk and compliance framework covering internal controls and risk management have been completed.*

⇒ *The implementation throughout the organisation needs however to be tackled and represents a major shift that will require attention to the human factor which goes beyond the current focus on policies, procedures and systems. Refer to section 9.3.1 for the related recommendation.*

6.2.5. Evaluation

At its special session in November 2011, the EB requested the DG to develop a formal evaluation policy that would set-out the institutional arrangements for evaluation at WHO. The major challenge at the time was the absence of a coherent organisation-wide policy on evaluation and a lack of consistent oversight by the EB on evaluations led at the Secretariat and the use of these results.

- *The new evaluation policy was endorsed at the EB 131st session in May 2012.* To address the institutionalisation of the policy, a Global Network on Evaluation (GNE) was set-up in April 2013, with a wide membership, comprising 23 representatives from the three levels of the organisation. The GNE is composed of different taskforces, addressing operational elements to further the implementation of the policy, from reporting on evaluation results to knowledge management. This has been supported by the

development of a handbook on evaluation practices to accompany and guide units and departments, in the planning and roll-out of programme evaluations. Feedback from some WRs is that the purpose of the GNE should be clarified and communicated. A challenge will be to address the 'lack of an evaluation culture', mentioned by several interviewed. In the survey conducted by IOS in July 2013 on the evaluation function at WHO, whilst 95 % staff concluded that they valued evaluation as part of WHO programme management, only 31% had received a specialised training on evaluation methods at WHO or 48% reported their activities being formally evaluated.

- *As requested by the EB, the JIU review on decentralisation and administration was completed in 2012, providing rich findings on the status of WHO's administration procedures.* Following this evaluation report, the stage 2 evaluation is in the process of completion. The next step for WHO will be to carefully act on the utilisation of the findings of these two evaluations.

6.2.6. Communication

The H1N1 pandemic of 2009 and WHO's shortcomings in the management of its response to media on the outbreak, has pushed the organisation to revisit its communication function. Over the last year, WHO's communication department at HQ has undergone a radical organisational re-structuring, leading to the consolidation of its communication function centrally rather than across the various technical units of the organisation. The aim is to ensure greater coverage and impact, while also ensuring staff have cross-functional skills to address emerging communication needs. To that end, a number of activities are underway:

- *Communication capacity and coordination have been strengthened*, e.g. staff are being trained in public health messaging and a pool of 24 officers has been trained in March 2013 in crisis communication to be deployed in situations of pandemics. A Global Communication Forum is planned for November 2013 and will bring together HQ and regional staff to align communication policies.
- *Mid-2012, WHO launched a stakeholders' perception survey to assess WHO's perceived value to key external stakeholders*⁴³. The survey findings are contributing to the development of the global communications strategy for WHO, which is underway at the time of writing this report. The process for doing so has emphasised wide ranging consultations with HQ, regional and country staff. Focal points at regional level have been selected to lead the process in their respective regions, for a more bottom-up approach. The global strategy will be declined into regional communication strategies. A first draft is expected towards the end of 2013, against target.
- *While the biennial global stakeholder perception survey took place in 2012, the IET does not consider this activity alone to be sufficient to address the expected output of 'improving public and stakeholder understanding of the work of WHO.* Many other joint actions will be required to fulfil it and in particular, increasing communication around the work WHO does at country level. Interviewees have regularly mentioned that WHO has challenges explaining and selling its work to the international health community. Refer to section 9.2.1 for the related recommendation.

⁴³ WHO and Grayling, Stakeholder Perception Survey Global Communication Strategy Review, January 2013.

7. Programme Management

7.1. Background

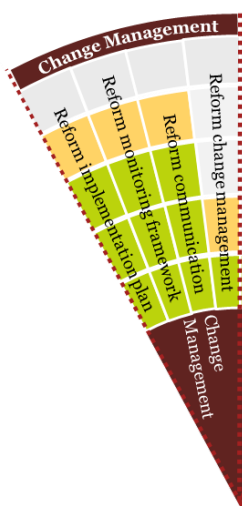
The HLIP for the reform considers the discipline of Programme management as part of the Change management area of the reform, alongside other change management activities.

This section focuses on reform programme management activities. For the purpose of clarity, in this section we use the Project Management Institute definition of programme: *“a group of related projects managed in a coordinated way to obtain benefits and control not available from managing them individually. Programmes may include elements of related work outside scope of the discrete projects in the programme”*.

Programme management rests primarily with the RST, a group created by the DG in June 2011 to add weight and coordination to the reform process. As part of the Policy and Strategy Development Unit, at the Director General’s Office, it is responsible to oversee, coordinate, track and report on progress made on the reform, as well as to take charge of change management of the reform. This structure is composed of a Director, two advisors and three officers.

We evaluate below the various elements that fall under programme management as opposed to the management of specific reform initiatives which has been discussed in the previous section.

7.2. Status



A number of programme management activities have been implemented and resulted in the following achievements:

- A delivery model for reform activities has been defined with roles distributed across the organisation.
- The reform program has been shaped and organised into a comprehensive and structured set of initiatives endorsed by the Secretariat and Member States.
- A HLIP and monitoring framework have been defined with an initial set of progress and performance metrics allowing for reporting to Member States.
- Budget and financial resources have been allocated.
- The organisation has managed to build momentum around the reform, has demonstrated some initial results and is showing drive to execute against the implementation plan.

It is, however, fair to say that the approach has to an extent been rather ad-hoc, the enthusiasm of the RST not completely making up for the absence of an experienced programme management skills. As programme management activities progressively mature the RST is revisiting the above and implementing more stringent programme management discipline.

Improvements underway relate notably to the implementation of a programme management tool to allow easier tracking and reporting of the various reform projects and initiatives. A rework of the theory of change on

reform is also in progress in order to strengthen it. The initial draft of a definition of a risk management plan for the reform was also presented to the October 2013 meeting of the IEOAC for feedback. This demonstrates willingness and responsiveness of the RST to make improvements to their programme management practices.

7.2.1. Reform Governance and Delivery Model

The first step to understanding the WHO reform is having a clear picture of the governance structure and delivery model for the reform process. *Also refer to the Change management section below for issues relating to leadership and change agents.*

Leadership

Within the WHO Secretariat, the *Director General* (DG), Dr. Margaret Chan, supported by the Deputy Director General (DDG) and advisors from the Director General Office, leads the reform process and is accountable to the EB and WHA.

The DG chairs the *Global Policy Group (GPG)* which meets four times a year and is composed of all six Regional Directors, the DG and the DDG. The GPG is the highest level of internal governance and its mandate is to set internal policies, ensure organisation cohesiveness and address issues of strategic priority for the WHO, one of those being the reform agenda. RDs interviewed made a number of suggestions to improve the effectiveness of this body, ranging from strengthened secretarial support, to preparation and duration of these meetings and to the follow-up on the decisions taken.

In May 2013 for the first time the *DG, RDs and ADGs* were brought together in a joint meeting. The Secretariat is now considering making what was initially an ad-hoc event a standing internal governance mechanism. The institutionalisation of this mechanism is key to the leadership of reform, given the need for coherence in both communication and execution of reform activities throughout the organisation.

At regional levels, *RDs* are owners of the reform and are supported by *Directors of Planning and Management (DPM)* and *Directors of Finance (DAF)*, who oversee respectively, the governance and programmatic priority-setting, and managerial aspects of the reform.

At the country-level, the *WRs* are the key figure responsible for implementing the reform agenda and for adapting it to the country needs, in line with the Country Cooperation Strategies (CCS). The relatively low degree of involvement of *WRs* in reform to date, the lack of platforms for exchanges between peers and the subsequent lack of readiness of *WRs* to fulfil their role is a key concern.

Management

The *Reform Support Team (RST)* mentioned in the introduction to this section has been made responsible for all aspects of project management and change management of the reform.

Additionally, *Business Owners (BO)*, generally Directors at the HQ level, have been assigned to manage discrete portions of the reform agenda and oversee their implementation at the three levels of the organisation. A total of 11 *BOs* oversee the fifty-one reform outputs and thirteen reform initiatives. *BOs* are responsible to plan their initiatives, mobilise the organisation around them and report progress to the RST.

Operationally, various *tasks forces* (e.g. Roles and Functions of the three levels of WHO), *working groups* (e.g. Planning PB 16/17 and Strategic Resource Allocation/Operational Planning) or *networks* (e.g. meeting of

Directors of Programme Management, meeting of Directors of Administration and Finance, Category Network meeting and the Global Network on Evaluation) comprising some of the above mentioned roles and functional specialists have been assembled to work on specific reform initiatives and outcomes. One challenge is keeping track of the activity of these various groups and ensuring the workload for those solicited in multiple working groups is manageable. Refer to section 9.4.1 for the related recommendation.

Reform is also an agenda item on the monthly meeting between the *eight Assistant Director General (ADGs) and the DG* which is separate from the GPG meeting. This consultative and advisory body reviews and provides feedback on reform progress and proposals from a more technical standpoint.

Oversight

Member States oversight is performed primarily through the *PBAC* where reporting on reform progress happens (refer section 7.2.4 below). This reporting happens mostly in two forms:

- Reporting on the overall programme progress, e.g. through the presentation of the WHO reform progress⁴⁴ or the HLIP⁴⁵ (May 2013).
- Specific agenda items relating to discrete elements of the reform, e.g. the cost and financing of Administration and Management or agenda item on the PB 2014-15.

The *PBAC* issues a report to the *Executive Board* which contains reform related observations and recommendations, amongst reporting on other agenda items. Specific reform initiatives such as the engagement with non-state actors or global health governance (EB 133) are also discussed directly by the *EB*.

It also reports directly to the *WHA*, for example on the progress of implementation of the reform⁴⁶, where it highlighted the need to strengthen performance measures and requested additional information on the implication of the reform budget reduction and the role of regions in the process.

The *IEOAC* has also been tasked with providing oversight over reform activities. The *IET* was notably able to observe the 3 July and 16-18 October 2013 *IEOAC* meetings where the manager of the *RST* presented a reform status update. The *IEOAC* then provides a separate report to the *PBAC*. Currently the *IEOAC* is still finding its feet in executing oversight on reform in terms of its role and value.

Ad-hoc independent evaluations of the reform are also being conducted, with stage one by the Auditor General of India in May 2012 and the present stage 2 in January 2014.

⁴⁴ WHO reform, Consolidated report by the Director-General, 65th World Health Assembly, 25 April 2012.

⁴⁵ WHO reform, High-level implementation plan and report, 66th World Health Assembly, 10 May 2013.

⁴⁶ WHO reform, High-level implementation plan and report, Report of the Programme, Budget and Administration Committee of the Executive Board to the 66th World Health Assembly, 20 May 2013.

⇒ *With the exception of a dedicated RST and reform business owners, most reform activities are governed through existing roles, structures and committees. Whilst alternative and dedicated structures could have been envisaged we see this as a strength in the sense that it ensures that reform is at the heart of how WHO conducts its daily business.*

⇒ *The current approach does, however, require a number of adaptations to ensure those roles and structures are fit for reform purpose and that their execution is conducive to an effective reform. Refer to section 9.4.3 for the related recommendation.*

7.2.2. Reform programme scope management and prioritisation

With 143 deliverables addressing governance, management and programmatic priorities, the WHO reform package has an extensive scope. Stage 1 of the evaluation validated the relevance of this scope as defined at the time of the evaluation in May 2012.

This scope has been communicated clearly in the reform HLIP, which was presented to Member States in January 2013 and endorsed in May 2013. A “Our reform story” one pager was also produced in May 2013 to provide a synoptic chart on the scope of reform.

This does not mean, however, that the reform scope is frozen. Following JIU recommendations to revise the administration of justice (2012) WHO management decided to include a new deliverable on enhanced administration of justice in the reform of human resources.

Reform related activities attracting both attention and resources create a risk that this scope becomes under pressure of various demands from corporate initiatives to be wrapped into the reform package. This is a feedback we obtained from the RST and from various Directors in the GMG cluster. The pressure is notably visible during the operational planning process for 2014-15 which included planning for reform (refer section 7.2.6 on resource management below). Management has however identified the need to ensure the package remains manageable and is resisting these pressures. An example is the Geneva HQ building renovation plan which although transformational in its potential, is managed as part of the Capital Master Plan and is not included in the reform package. The fact that the definition of the next generation GSM system is not formally part of the reform package follows the same logic. Moving forward, there is no formal process by which the reform scope will be re-assessed, e.g. the PB 2016-17 may generate new needs on reform. Refer to section 9.4.2 for the related recommendation.

Despite the relative control over the scope of reform, the challenge remains that the breadth of reform initiatives that are under management and oversight attention is vast and takes a toll on scarce Member States and management time. The challenge to maintain focus and control will only be compounded as reform initiatives move through the various stages of implementation. Also as progress needs to be demonstrated, there is a risk that focus shifts on implementing initiatives that are comparatively easier (e.g. communication, traffic light system) as opposed to initiatives of a transformational nature which would result in the greatest impact for the organisation’s strategic positioning and effectiveness (e.g. engagement with non-state actors, strengthened technical excellence). Whilst this is commendable in order to build momentum, tackling major items of reform cannot be left to too late.

In this context, principles and mechanisms to prioritise focus are important if reform is to remain under Member States and Management control. Options to do so relate to the delegation of management and oversight to specific bodies based on priorities, sequencing reform activities over a longer period of time and improved effectiveness of planning and coordination. A more robust theory of change for reform would also allow for identification of priorities within the reform package. Refer to section 7.2.4 below.

⇒ *A prioritisation of achievements to be obtained at various time horizons of the reform, as part of the reform's theory of change, would allow improved prioritisation and focus on underpinning initiatives. Refer to section 9.2.1 for the related recommendation.*

7.2.3. Planning and coordination

Planning and coordination of the reform programme are supported at a management and oversight level by the HLIP and at an operational level by a complex spreadsheet with no less than 69 columns. These tools are available on WHO's external website, although the latter with reduced usability.

Planning is done against deliverables and outputs. Consequently the plan is only as comprehensive as the outputs and deliverables contained in the plan. Since the **Figure 2** on page 25 shows that the outputs and deliverables contained in each initiative do not necessarily address the whole scope of required activities to institutionalise change, the plan suffers from shortcomings. The best illustration of this is that in these tools, the time horizon for reform activities stops at 2015, despite the obvious fact that reform will take longer to be fully implemented and institutionalised. It mostly focuses on the early stages of transformation, e.g. assessments, strategies, frameworks and policies. This does not mean that the Secretariat is not following through in full implementation and institutionalisation of change, but in the current state of affairs, the implementation plan does not allow to identify, capture and track progress throughout all required activities to effect change.

As they currently stand, the HLIP and its supporting spread sheet are fit for purpose from a reporting to oversight bodies point of view, but fall short of being an operational tool that will allow predictability and smooth scheduling of activities in such a way that brings coherence among the substantial number of reform related tasks and activities currently underway at all levels of the organisation, not only at HQ.

As a result the structuring of the reform planning is primarily done to support reporting to Member States. The broad milestones presented are not complemented by detailed operational plans outlining 1) what is realistically achievable between two EBs; 2) what steps and monitoring of progress need to happen between two such governing body meetings. This creates a tendency to slow down after governing body meetings and to rush before meetings as opposed to a more predictable and smoother workload. The consequence is the pressure put on consultation and review, which can impact on the overall quality of work product and on stakeholder buy-in. This was a frequent feedback from ADGs and regional DAFs interviewed.

Some BOs have defined project plans for their initiatives (e.g. for the initiative on strengthened culture of evaluation or communication strategy) but:

- These are not performed in a consistent manner nor are they supported by clear guidelines from the RST for the development of such action plans.
- They are not consolidated by the RST into the overall reform plan.
- The production of a project plan by BOs that would allow for easier identification of risks, dependencies and possible operational and managerial bottlenecks is not systematic.

Concurrent progress on a number of initiatives (e.g. 17 outputs from 9 different initiatives are in implementation mode) will increasingly cause challenges in coordination and workload on Member States and staff as reform moves into implementation. As pointed out in section 7.2.2 above it will be challenging to keep Member States and staff on board. Although a number of stakeholders, most notably donors, have pointed out to the need for fast results, we obtained widespread feedback from Member States, management and staff alike that the pace at which reform is being executed would either require much more resources, predictable planning and focus on change management activities, than is currently deployed, or need to be revisited to

ensure those Member States and staff stay on the journey. For example, the consultation with regional and country levels on change proposals although it is happening does not allow for sufficient time for internal discussions and absorption of comments and is not conducive to pushing ownership of the reform process across the organisation.

The concurrent progress on a number of initiatives (e.g. internal controls and risk management, or the HR strategy and need to strengthen country offices) is already causing challenges in coordination within the limited circles of key reform actors. As those initiatives move through implementation, the burden on Member States and the Secretariat will be substantial and there has not been an assessment of whether those stakeholders would be able to absorb what is submitted or required from them.

The RST is aware of this challenge and has invested in a project management tool that was in prototyping at the time of writing of this report. The demonstration made to the IET gives confidence that although not a 'silver bullet', this should address some of the above shortcomings.

This does not however address the scarcity of project management skills across the stakeholders involved in reform. Only one person in the RST has a project management certification and to our knowledge none of the BOs are supported by experienced project managers.

⇒ *Overall there is a strong case for strengthening short and long term planning and coordination of reform activities. Refer to section 9.4.2 for the related recommendation.*

7.2.4. Reform programme monitoring and reporting

Aside from reporting on discrete initiatives, from a programme management point of view the key monitoring mechanism used to track and report progress on reform is the reporting to PBAC, IEOAC, EB and WHA on the reform HLIP.

The plan compiles the set of reform initiatives into a consolidated reform package which articulates the reform programme via a result chain where impact is defined for each of the four reform areas, outcomes and KPIs are defined for each of the 11 reform initiative and then supporting outputs (51) and deliverables (143) are defined with related target completion date and current status.

So far, progress has been reported against each output and deliverable using the following status:

- To commence: planned activities have not yet started
- Ongoing: planned activities have commenced but are not yet completed
- Completed: planned activities are completed and output delivered
- Continuous: planned activities have commenced and have been mainstreamed into the work of WHO
- Partially complete: planned activities have commenced but were not completed within the original planned deadline

The above has allowed a degree of transparency in reporting to Member States. We understand the RST is considering adopting the status definition used by the IET in this evaluation.

As mentioned in section 7.2.3 above, the fact that reporting is on the basis of outputs and deliverables means that the robustness of the reform result-chain is paramount to support effective monitoring and achievements of desired outcomes and impacts.

In a number of respects the reform result chain and theory of change are still a work in progress:

- Indicators to measure the impact of reform in terms of improved health outcomes, greater coherence in global health and an organisation that pursues excellence are those presented as part of the 12th GPW; the link between outcomes and impact is tenuous however.
- Some outcome indicators are weakly linked to the outcomes they are meant to quantify, e.g. the achievement of the outcome “staffing matched to needs at all levels of the Organization” is measured through the outcome indicator “% of recruitment processes completed within 180 days” or “managerial accountability, transparency and risk management” is measured through the proportion of corporate risks with response plans approved and implemented.
- Baseline information is not available on 9 out of 18 outcomes indicators whilst targets for 6 out 19 outcomes indicators are either missing or vague (e.g. “progressive improvement”).
- The logical linkage between the areas of reform and their supporting outcomes and outputs is not articulated within a robust theory of change.

- Outputs and deliverables are mostly of an ‘Assess and Strategise’ and ‘Design’ nature (33% and 51% respectively). This means that the reporting of completion of these outputs and deliverables can give a false sense of comfort that reform is far advanced when the status of implementation activities is not tracked.

Overall the reform result chain does not support adequate reporting.

Also the fact that reporting is mostly targeted to Member States means that it mostly focuses on six-monthly updates as opposed to continuous reporting and managerial reporting that would complement the above with more detailed and operational reports in order to facilitate internal steering of the reform process.

Reporting on overall reform progress also happens at regional level, although reporting is not consistent across regions and can range from passing on documents produced for the EB and PBAC to specific reports on impact and progress of reform in the region, as what the EURO Regional Office produced for their 2013 Regional Committee meeting. Moving forward, as reform moves across the various levels of the organisation, such regional reporting will be key to ensure oversight and buy-in at regional level.

The reform monitoring framework also does not give precision on how the implementation of reform initiatives at regional and country level will be tracked and monitored. Whilst this is inconsequential in the early stages of strategising and designing, it will be key as initiatives move towards implementation. This requirement should notably be factored in the reform programme management tool and upcoming guidance to Business Owners.

⇒ *The reform monitoring and reporting framework needs to be strengthened and reporting of progress of activities and realisation of expected benefits, risk and resource utilisation need to move from being **event driven** (e.g. PBAC presentation) to a **continuous process** supporting management and execution. Refer to section 9.4.2 for the related recommendation. Refer to section 9.4.5 for the related recommendation.*

7.2.5. Risks and dependency management

The reform HLIP contains a short section on dependencies and risks, albeit in a very succinct way. So far risk and dependency management have not been a formal and integral part of how the reform programme has been managed.

In order to make up for this, the RST has produced a comprehensive risk management plan for the reform which captures key risks for each reform initiative and allocates both risk ownership and risk mitigation activities. This plan was presented in draft at the 16-18 October 2013 IEOAC meeting.

Whilst this is a good start, two constraints need to be mentioned: **1) the organisational culture of risk management is weak, so the RST cannot ensure that merely defining the framework will be enough; 2) a material portion of high risks are governance-related and their ownership and mitigation primarily rests with Member States although the Secretariat can support in some mitigation.** There is currently no defined process to transfer the ownership and treatment of these risks where it belongs.

This also leaves open the need to get a better handle on the management of dependencies. The programme management tool mentioned above will allow business owners to identify dependencies internal to their projects.

The following remains unclear however:

- How dependencies will then be consolidated, monitored, managed and reported at a programme level
- What communication will happen between all of the dependency-related parties
- What action plans will be identified, agreed and implemented to manage dependencies
- How dependencies between reform initiatives (e.g. between Administration & Management financing and Financial dialogue) or with events or initiatives external to the reform will be managed (e.g. between Accountability & internal controls and the future of GSM).

Improving the management of dependencies is important since dependencies go beyond a specific initiative. A separate set of meetings and liaison responsibilities to address these types of dependencies may need to be created, resourced and managed which may not have been fully understood when the project was first initiated. Also the “owner” of each dependency may not be aware of the influence or inter-relationship with other initiatives, and this may need to be defined and communicated clearly.

⇒ *There is a strong need to improve the management of risks and dependencies as an integral part of the reform programme monitoring and reporting. The Organization also needs to find ways to allocate the treatment of governance risks where they belong: with Member States. Refer to section 9.1.3 and 9.4 for related recommendations.*

7.2.6. Resource management and budgeting

Budgeting

The reform budget for 2012-13 was initially done in January 2012 as part of the definition of the implementation plan which identified outputs agreed to by Member States following the 132nd session of the EB. Each business owner identified their resourcing needs against the output and deliverables they owned, and this was reviewed with the RST. A significant portion related to additional staff in HR, PRP and IOS.

The consolidated additional resource requirements were budgeted for \$19.8 M and covered:

- Staffing costs for the RST
- Incremental staffing for reform initiatives
- Activity costs relating to reform initiatives

The reform budget does not account for:

- Time spent on reform activities by existing WHO staff not part of the RST
- Potential restructuring or severance costs that specific initiatives may generate
- Ongoing costs generated by reform activities, e.g. new positions in IOS, PRP or the new ethics and compliance function
- Savings that may result from potential efficiency gains coming out of reform initiatives.

Between January 2012 and May 2012 a re-costing exercise was done which brought down the budgeted expenditures to \$17.8 M due to delays in staff recruitment or some initiatives starting later than anticipated.

For 2014-15, reform activities have been mainstreamed into the PB and are being planned as part of operational planning at the time of writing of this document. There remains a challenge for the RST to ensure activities and deliverables supporting the reform are adequately planned by BOs and to ensure a clear differentiation between reform project activities and ongoing costs introduced by the reform. A case in point, there has been no 'meetings of BOs' to align and harmonise risk management, budgeting, planning or to discuss dependencies. It is also unclear how reform activities at regional and country level are consolidated as part of this operational planning exercise. This does not allow the IET to comment on the sufficiency of resources allocated.

Financing

The initial \$19.8 M budget figure for 2012-13 was used to define a brief funding proposal in 2012. On this basis a number of donors have provided voluntary funding amounting to \$9M so far, of which \$5M has been distributed to date. Additionally the DG has made available \$5M in CVCA to business owners.

Overall despite the fact that budget has been so far consumed at a slower pace than anticipated, the funding gap is currently \$5.7M, which will be critical to bridge given the important volume of reform activity planned in 2014-15.

⇒ *Since reform activities are primarily financed through voluntary funding, it is important that sufficient funding to drive, implement and sustain the programme of reforms is secured over the lifetime of the reform programme. This could prove challenging since donors have not shown great interest in funding category 6. However specific financing of reform activities should be seen as an investment in the future-proofing of the Organization.*

Expenditure tracking, monitoring and reporting

The operational management of the reform budget is delegated to each business owner's budget centre. We understand that this has created concerns with some BOs who did not want to go over their budget ceilings and budget space.

This is also proving challenging for the RST to manage and monitor. Reform related expenditures in 2012-13 are only identified through a line in the budget centre's workplan. It requires a rather tedious manual process for the RST to reconcile these aggregated expenditures against specific deliverables contained in the HLIP.

We understand this would improve in 2014-15 since all reform deliverables will be identified in the operational plan and traced in GSM. Also staff are not recording their time which makes it difficult to estimate the true total cost of reform activities.

Reforecasting is done in January and May prior to each EB meeting and presented to the PBAC as part of the update on reform. We understand in January 2014 a report on 2013 and a plan for 2014 will be presented to the PBAC. The RST also provides four monthly reports to the IEOAC. Apart from this there is no consolidated ongoing monitoring of reform expenditures by the RST.

⇒ *Resource management presents a number of challenges relating to:*

- *Adequately estimating and planning for reform activities*
- *Costing the overall cost of reform as opposed to the incremental costs that need financing*
- *Linking costs with outcomes of reform initiatives*
- *Factoring in the financial efficiency and cost savings accrued through reform initiatives.*

Refer to section 9.4.2 for the related recommendation.

7.2.7. Quality assurance and evaluation

For conciseness sake, quality assurance and evaluation processes, although they are different in nature, are treated jointly in this section.

The consultation that happens in each initiative (e.g. with DPM/DAF networks) to review outputs and deliverables also acts as a quality management mechanism, although there is no formal way to ensure that feedback obtained is actually considered and taken into account in the final deliverables.

Finally the introduction of an agenda item in the IEOAC on reform offers an avenue for the IEOAC to perform oversight over quality assurance processes. The information that is provided to the IEOAC is however similar to what is provided to Member States. Specific and independent input to the IEOAC on reform progress should be provided to the IEOAC in order for it to play a meaningful role. Steps have recently been taken in that direction with the presentation of the reform risk register at the 16-18 October 2013 session of the IEOAC.

Aside from the above there are no formally defined reform related quality management standard, processes and roles that would outline the nature, timing and extent of planned assurance, quality reviews and embeds learning. There is no central point of coordination of the substance and quality of what is produced by each reform initiative so that results are achieved, rather than merely delivering on outputs. This can create some inefficiency in ensuring the coherence of various parts of reform.

Independent evaluation processes consist in the performance of the stage one and stage two independent evaluations of the reform. Whilst these provide a valuable outside-in view, these may not be timely enough to ensure continuous improvement and to enhance a learning culture. We also observe that at this stage there is no stage 3 evaluation planned which would focus on results of the reform at impact and outcome level.

We are of the view that an ongoing quality assurance and regular evaluation processes should be implemented to ensure ongoing and timely feedback. This could take the form of independent quality assurance checks on programme management activities as well as quality review of the outputs and deliverables of each initiative. A summative evaluation should also be envisaged towards the end of each biennium to verify the results achieved by the reform at impact and outcome level. In doing so, care should be taken not to put unnecessary burden on the Secretariat and take focus away from execution.

⇒ *Quality assurance and evaluation processes and structures need to be defined. Refer to section 9.1.3 and 9.4.4 for related recommendations.*

8. Change management and communication

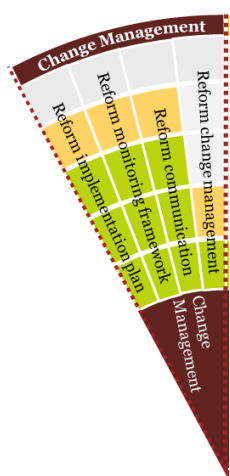
8.1. Background

Change management and communication is critical in turning a change initiative into success, accelerating the delivery of benefits, increasing "stickiness" of changes and ensuring their sustainability. This is achieved through the application of a number of change management and communication activities and techniques. These cross cutting activities span the whole life cycle of a transformation.

As mentioned in section 7 above, the discipline of change and programme management activities for the reform are grouped in the Change management area of the reform and are managed by the Reform Support Team.

This section of the evaluation focuses on specific aspects relating to leadership and vision, change network, communication and stakeholder management, impact assessment and performance management. It builds notably on the findings from a staff survey carried out in September and early October 2013.

8.2. Status



Two work products are defined in the HLIP to support change management of the reform. Firstly a communications and engagement strategy for external and internal stakeholders to maintain awareness, trust and commitment. This document was produced in draft form in October and November 2012. It provides a communication plan for the October 2012-June 2013 period. Secondly an organisational framework to manage change which is a 3 page document which mostly cross references the HLIP, monitoring framework and the above communication and engagement strategy.

In practice, interviews have demonstrated a commitment to reform from WHO elected leadership at HQ and regional level. Also, senior management at HQ, regional and country level are engaged, however at varying levels. Whilst the key requisite for success is in place, engagement with Technical Directors and WRs has yet to be addressed.

The engagement model for Assistant-Directors General, Regional Directors and Directors across the three levels to lead different Taskforces and Working Groups on reform is making up for shortfalls in WHO's governance structure.

Tools to enhance awareness have included the development of the reform infographic, three newsletters and web updates on the WHO reform, engaging Member States through SharePoints and opening up the Financing Dialogue of June 2013 to remote areas through video-conferencing. There is clear commitment from the Secretariat to improve its communication on the WHO reform.

Some capitalisation on reform headways made in several regions on various topics has happened (e.g. RBM, mobility, country support units, global health diplomacy training) which builds credibility and facilitates acceptance in other regions for what could otherwise be seen as HQ imposed reform.

After an initial successful focus on Member States change and communication efforts are now being redeployed to address staff at all levels of the Organization. The results from the staff survey and interviews carried out with staff and management show that there is some way to go to ensure an inclusive process, build commitment and for these reform to have its impact on the organisation.

A missing critical piece is a thorough assessment of the desired and undesired impact of change on each stakeholder group that could guide and ensure the relevance of change management and communication activities.

8.2.1. Leadership and vision

A clear vision for the reform has been consistently promoted since 2011, building on the progressive realisation throughout 2010 that addressing WHO's financing challenges required a holistic approach to the future-proofing of the organisation.

This case for change and vision for the reform are best articulated in the Director General's opening statement to the Special Session of the Executive Board in November 2011 (EBSS/2/INF.DOC./9) and the "WHO reforms for a healthy future" paper presented to the same session (EBSS/2/2). The DG's personal commitment to what will be seen as her legacy has not only been demonstrated through her various addresses to Member States but also through the means allocated to reform and the management attention she is dedicating to the reform process. In many ways she is personifying the reform. Whilst this is positive in itself, one challenge moving forward will relate to the timing of the end of the DG's term and the impact of this on the requisites to institutionalise key reform achievements before the end of her term in June 2017 and to ensure that those activities still underway by then are brought to their successful completion under a new leadership.

Interviews with Regional Directors have also generally confirmed their buy-in into reform process, and a number of reform initiatives actually originated from regional offices, e.g. the identification of roles of the levels of the organisation in EURO, bottom-up planning in EMRO, or the mobility policy in WPRO.

In the absence of a "command and control" type of arrangement between the DG and the RDs, the GPG described in section 7.2.1 above is the forum where shared ownership and direction on the reform can be forged and agreed. Its recent creation (March 2012) has proved instrumental in aligning regional and HQ leadership and ensuring RDs ownership of the reform. Some of the RDs interviewed made practical suggestions for how the GPG effectiveness could be strengthened.

Also one area of progress relates to the alignment between the GPG and ADGs. There has up to now only been one ad-hoc meeting where this extended leadership team has met. Moving forward, and in the spirit of fostering alignment and ownership of reform, it makes sense for such a group to convene at regular times.

⇒ *There is a clear and demonstrated commitment from leaders at global and regional level for reform. This important requisite for success is in place.*

8.2.2. Change network

The core internal change agent network is relatively straight forward to identify and consists of:

- *Senior leadership and management*: this includes DG, RDs, DDG, DGO who can be seen as the owners of the overall reform package. This group has regular and ongoing opportunities to engage and promote the reform agenda
- *Business owners for reform initiatives*: 11 persons. Interviews with this group have shown that they are generally well engaged in the reform process. Given their critical role, in the reform process, ensuring their full and ongoing commitment in driving the reform is paramount. One challenge relates to how well these change agents are supported by the RST or other functions (e.g. DGO, GMG/PRP) in delivering their outputs and deliverables, notably in terms of communication and having adequate forums to coordinate their activities. Refer to section 9.4.3 for the related recommendation.
- *ADGs and DPMS*: 14 persons. Whilst this group is formally involved in the reform process, and had strong input into the programmatic reform notably, the feedback on the quality and timeliness of their involvement we obtained from our interviews was mixed. A number of ADGs pointed out that although they were formally consulted on some reform proposals, they were not provided with sufficient time to absorb the content of proposal and provide meaningful feedback. There were also questions raised on whether feedback was actually taken into account in final proposals and designs. This group is also most impacted by the implementation of Category Networks. Refer to section 9.4.3 for the related recommendation.
- *Directors within GMG and DAFs*: this group of 14 persons is heavily involved in the reform process, mostly through the managerial and programmatic areas. In our survey, out of 17 D1-D2 working primarily in category 6, 87% agreed and strongly agreed that the WHO reform will be important to make the Organization more 'fit for purpose' in the future. 80% agreed and strongly agreed that the work underway on reform will improve the effectiveness of the organisation, none denied that they had been well informed by management about the reform process, and 2/3rd agreed or strongly agreed that they knew what was expected from them to make the reform successful. This shows strong engagement and support.
- *Directors of technical programme and units*: 64 persons at HQ and in regions. This group will be most affected, positively or negatively by shifts in programmatic priorities, resource allocation, strengthened accountability, result-based management and coordination of resource mobilisation activities. Our interviews with Directors have showed that the degree of buy-in into the reform is extremely heterogeneous. In our survey, out of the 25 D1-D2 technical staff who answered, only 56% of this group agrees or strongly agrees that they understand what is expected from them to make the reform successful. Less than half believe that the reform will have a positive impact on health outcomes and national health systems and only 39% agree that WHO reform will enhance the ability of their programme area to have more predictable and sustainable financing. It is also clear from interviews that these Directors are not provided with a sufficient level of information (e.g. talking points) to relay key reform messages or address staff questions.
- *WRs*: 150 persons. This group is the most remote from HQ and regions, yet the ultimate success of reform will rely on them. Interviews with twelve WRs have shown a general buy-in into the reform agenda. However it was apparent in interviews that this group has had little involvement in the reform task forces to date and little more information on the reform than general staff. Consequently they do not feel in a position today to "own" the reform at their level, which has an impact on their ability to communicate the relevant elements of the reform with staff, Member States and other health actors at national level in a convincing way. This will have an impact when reform initiatives are rolled out to the field and in positioning WHO more strongly among health actors at local level.

⇒ Overall the success of the initial stages of reform relies on a limited group of around 250 well identified people.

⇒ Whilst most change agents buy into the reform and are engaged and supportive, Technical Directors and WRs require renewed attention. Refer to section 9.3.3 and 9.3.4 for the related recommendation.

Regarding the change agent network with Member States the situation is less clear. Besides Secretariat leadership, the following change agents can be identified:

- Special envoy for the financial dialogue and for engaging with non-state actors: this role has proved instrumental in facilitating consensus building among Member States on the future financing of WHO.
- IEOAC members: the IEOAC can provide valuable views from the outside in its reports to the PBAC and EB.
- Specific delegate or Member States representative, depending on their interest in specific initiatives.
- WRs: given their proximity with Ministries of Health, WRs can play an important role in advocating reform and assisting Member States in the preparation of EB, WHA and RCs so that the desired increased focus on decision making actually happens.

Besides ad-hoc approaches there has not been a systematic thinking on building a change agent network with Member States.

⇒ The change agent network is primarily Secretariat driven, which limits its ability to impact Member States behaviours and commitment to reform. As a result those governance risks that could impact the success of reform are not currently mitigated. Doing so will require innovative approaches to push influence, ownership and accountability on Member States side. Refer to section 9.3.5 for the related recommendation.

8.2.3. Communication and stakeholder management

A communications and engagement strategy for external and internal stakeholders has been produced in draft form in October and November 2012. Its goal is to maintain awareness, trust and commitment. It provides a communication plan for the October 2012-June 2013 period. Also a short organisational framework to manage change has been formalised which mostly cross references the HLIP, monitoring framework and the communication and engagement strategy.

A number of communication activities are taking place with Member States and staff. They include among others:

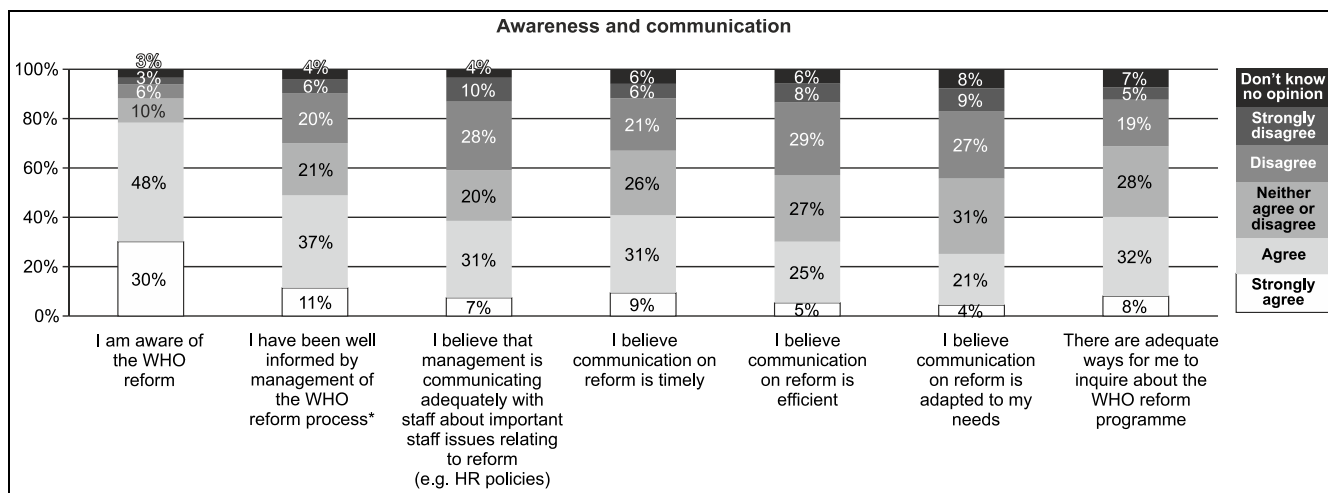
- A reform website which compiles all official documents on reform;
- A one pager infographic which outlines reform goals, areas and initiatives;

- A Change@WHO newsletter of which 3 issues have been published to date;
- Briefings from ADGs to their teams;
- Briefing from RDs to their teams.

From a review of the available communication material, we note that communication content until recently primarily targeted Member States and was then re-used for internal purposes, without taking into account specific internal stakeholder needs. After this initial successful focus on Member States, change and communication efforts are now being redeployed to address staff at all levels of the Organization. The survey provides valuable insight on reform communications.

We asked an initial set of questions on reform communications. The overall results are presented in **Figure 4** below:

Figure 4. Overall survey results on the awareness and communication on reform



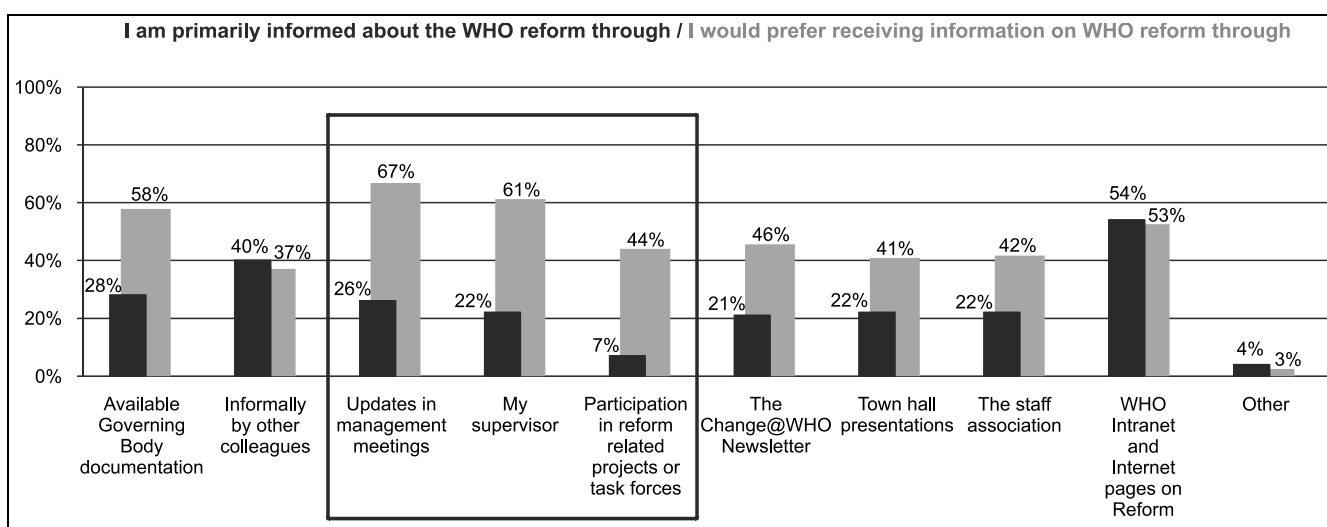
Based on this chart, the following observations can be made:

- First, less than half (48%) of respondents agree or strongly agree that they have been well informed by management of WHO on the reform process, with better scores in the regions of AFRO (65%), SEARO (56%) and WPRO (54%) and lower scores in AMRO (40%), and EMRO (33%);
- Second, only 40% of respondents agree or strongly agree that communication on reform is timely and 30% only that communication on reform is efficient. Highest scores are found in the AFRO and WPRO regions and lowest in HQ, followed by the AMRO and EMRO regions;
- Third, in terms of the content of reform communication, only 25% of respondents believe that communication on reform is adapted to their needs and 38% that management is communicating adequately with staff about important staff issues relating to reform (e.g. HR policies). Highest scores are found in the AFRO and WPRO regions and lowest in HQ, SEARO, AMRO and EMRO regions. Throughout our interviews with staff at all levels of the organisation, we obtained feedback that communication is seen

to focus on the process of reform, as opposed to the content and impact of reform initiatives. This feedback was particularly prominent with technical staff and management.

The main channels through which staff is informed on reform are the WHO intranet and internet pages on reform (used by 54% of respondents) and informal discussions with colleagues (40%), mechanisms that are ill suited to elicit engagement and support for the reform. Only 26% mention updates in management meeting, 22% information from their supervisor and 7% involvement in reform related projects or taskforces as primary means of information. These contrasts sharply with the preferences staff mention on how they would rather receive information on the reform. 67% mention updates in management meetings, 61% their supervisor and 44% participation in reform related projects or taskforces as their preferred channels.

Figure 5. Overall survey results on the primary sources of information on reform



Paradoxically, despite the above, interviews with staff and management also mentioned a perception of communication overload on reform, seen by some as being detrimental to the attention that needs to be paid to WHO’s substantive or technical activities.

⇒ *The results from the staff survey and interviews carried out with staff and management show that there is some way to go to ensure communication moves from a broadcast and information mode to one where information is tailored to recipients needs and proper engagement with staff takes place. Refer to section 9.3.2 for the related recommendation.*

8.2.4. Change readiness and Impact assessment

An organisational Impact Assessment is meant to ensure that change activities are focused and appropriate for the level and type of impacts generated by the change. It notably identifies the impact of the change for people, structures, processes and systems in such a way that what is new, what is stopping and what is to continue for each of these dimensions is understood and documented.

This assessment should be coupled with a high level assessment of the change readiness of the organisation, which addresses the conditions for success of the change initiative such as clarity of business benefits, degree of engagement of end-user population, management skillsets and culture.

Together the change readiness and impact assessment identify impacts, possible change risks and the organisation's capability to implement change in order to inform the communication, risk and change management activities required to shift behaviours and transition the new ways of working.

⇒ *We did not find evidence of a consolidated assessment of the desired or anticipated impact of each reform initiative on the WHO workforce and different staff levels that would guide the communication, risk and change management approaches. Refer to section 9.3.1 for the related recommendation.*

8.2.5. Training

Training requirements coming out of the reform fall in two categories. Foundational skills required to implement reform and training requirement coming out of specific initiatives.

On the former, WHO through the reform is trying to implement new ways of working by applying traditional ways of working. The shortcomings identified in project, planning, risk, change and communication management are an illustration of this challenge. As already mentioned the fact that the Reform Support Team is tackling such an ambitious task with only one certified person in project management strongly constrains success. We did not identify a plan to train Reform Support Team, business owners or change agents in the above matters.

On the latter, some ad-hoc initiatives have taken steps to train staff on the required skills. Emergency communication trainings were conducted in March 2013, attended by 24 staff, 75% from the country offices, in response to the recommendations from the Review Committee on the Functioning of the IHR (2005) in relation to Pandemic (H1N1) 2009, to strengthen strategic communication in response to pandemics. Communication trainings on public health messaging have also been offered to non-communication focal points, namely resource mobilisation officers and country office staff. Also a specialised training is being offered to WRs since 2012 on global health diplomacy. The course has focused on the importance for WRs to be able to navigate complex multi-stakeholder and political environments which require increasing levels of diplomatic skills.

The above examples do however come across as exceptions. Few other BOs have planned and budgeted for training activities as part of their initiatives. There is also no consolidation of reform related training needs by category of stakeholders. Currently the HLIP includes a total of three reform-related trainings, i.e. of new Board members, of WRs in global health diplomacy and a series of communication trainings for staff which have benefited all WHO regions. Regions have also conducted a number of reform-related trainings at their own

levels. This is the case for example in WPRO which conducted trainings in resource mobilisation for five of its country offices and communication trainings for its country focal points (2013); the training of 300 staff members on AMRO's new risk management framework (2013) and leadership trainings for its WRs. There is no consolidated budget for training activities planned in the reform budget, although some BOs have planned certain training activities as part of their reform initiative (e.g. strengthening of the internal audit capacity at regional and country-level).

⇒ *Reform deliverables and activities need to take training requirements more into account. Refer to section 9.3.1 for the related recommendation.*

8.2.6. Accountabilities, incentives and performance management

Individual accountability and performance management of the reform is not systematically mainstreamed in the Secretariat's performance management framework, the PMDS. For example, reform deliverables and outputs are not necessarily included in the PMDS, objectives are not discussed or communicated to the RST, and this does not allow to align objectives between all parties for coherence.

Apart for the BOs, the other change network groups, notably the DPMS, DAFs, WRs and technical Directors, are currently not being coached to transmit the reform at their respective levels. This is done in a more organic, than systematic manner. Those with greater interest for the reform agenda will take on greater leadership. BOs deliverables have not been incorporated into their PMDS as of yet, hence the accountability for delivering on reform results is not linked to performance. Refer to section 9.4.3 for the related recommendation.

9. Recommendations

In this section, we set out proposed recommendations based on the findings of the evaluation. We have defined four overarching recommendations and the supporting actions required for successful implementation.

The first recommendation on ‘Ownership and accountability of Member States’ relates to their **dual responsibility for the success of the reform**. The necessary strategic transformation can only occur if the Member States take on this critical accountability. Hence, this first recommendation is addressed to this key stakeholder group.

The second recommendation, on **improving benefits management** through a stronger theory of change for the reform, relates to the strengthening of the reform monitoring framework and the resulting reprioritisation of reform activities. It is primarily directed at the RST and GPG, but should be endorsed by Member States.

The third recommendation to **develop and roll-out a change management plan** addresses the need for active change management. It is primarily directed at the RST and BOs.

The fourth relates to the **strengthening of programme management practices**. It is primarily directed at the RST.

These recommendations if implemented in a comprehensive manner will mitigate most of the barriers to change identified in the evaluation.

9.1. Recommendation # 1: Ownership and accountability of Member States

As ultimate funders, decision makers and beneficiaries of WHO services, Member States are not only responsible to provide oversight for the reform. They play a major individual and collective role in making the reform successful. This is notably the case for the programmatic and governance areas of the reform.

Whilst most of the ‘heavy lifting’ on reform rests with the Secretariat, Members States can play an active role in the success of the reform in three areas: fulfilling their duty of care for the Organization, notably through adequate financing; making the governance reform successful through a shift to more strategic decision making; and organising themselves to provide efficient and effective oversight over the reform.

9.1.1. Financial responsibility and duty of care

Efforts by the Secretariat to improve the flexibility, predictability and alignment of financing through the Financing Dialogue are a welcome innovation on which much hope is placed. Short-term results from this process will relate primarily to the channelling of voluntary funding to those areas where financing needs exist, with additional benefits in terms of increased transparency in WHO's financing and use of resources.

This process is, however, not addressing the fundamental challenge in the structure of WHO financing. In the PB 14-15 the weight of assessed contributions in the overall budget decreased to 23%, whilst demand from Member States on the Secretariat is ever increasing. Also close to 50% of the financing of the Organization is left to non-Member States, yet non-state actors do not have a proper seat at the table. In the long run these paradoxes are untenable.

We therefore make the following recommendations:

- **Increase Assessed Contributions:** as reform related improvements become tangible and confidence in the Secretariat builds-up, Member States should consider increasing their assessed contributions as a sign of trust and as a way to fulfil their duty of care. Whilst this is not realistic in the short term, this should be a goal for the 16-17 period onwards. An initial step could be to increase AC contributions to a third of the overall budget in 2016-17, with the view to achieve a balanced 50% AC-50% VC in the long-term. A requisite for this is a demonstration of early tangible reform outcomes by the Secretariat.
- **Extend donor base:** the potential pool of voluntary donors among Member States is much larger than today's concentration on 20 donors. As part of the Financing Dialogue, Member States should discuss their mutual accountabilities and those Member States not carrying a fair share of the financing of the Organization should be challenged.
- **Institute coherence between Member States as AC contributor and Member States as a donor:** The study on Administration and Management costs conducted in 2012-13 pointed out the sometimes conflicting behaviours by Member States when it comes down to programme support costs (PSC). On the one hand Member States do not want their assessed contributions to subsidise voluntary funded programmes, notably those funded by non-Member States. On the other hand some Member States put pressure on PSC applied to the activities they fund on a voluntary basis. We recommend that Member States clearly commit and communicate a policy to their various departments (e.g. Ministry of Health and Ministry of Foreign Affairs) that the standard PSC rate is not to be an area of negotiation in grant discussions with WHO and that it should be funded.

The above if implemented will go a long way towards solving WHO's financing challenges.

9.1.2. *Shifting to strategic decision-making*

With structural changes to governing body meetings proceedings now implemented, much of the success of the governance reform relies on Member States actually shifting to more strategic decision-making. This involves a manageable number of items to be discussed at governing body meetings, an adequate degree of preparation for governing body meetings and proper handling of meetings and discussions by Member States.

Against this background, we make the following considerations:

- **The support for and role of committee chairs in effecting proper division of labour and coordination between committees should be reinforced.** This includes notably:
 - **Adequate definition of skills, training and support requirement for committee chairs.** The role of committee chairs is intensive, not just during meetings themselves but also inter-sessionally. The support provided by the Secretariat should be tailored to the experience and support available to them in their home countries. The process of induction of committee chairs could also be used to assess training needs for chairs. Where needed, this could take the form of peer coaching from previous chairs or retired chairs. Some criteria for the experience, skills and attitudes in the appointment of chairs should also be explored.
 - **Setting-up a formal process to ensure regular communication between the chairs of EB, PBAC and RCs is strengthened prior to and after governing body meetings.** This will ensure proper delineation of focus and clarify expectations and modalities of required information flows between the committees.
 - **Ensuring that chairs and bureaus are empowered to define a manageable agenda for meetings.** The EB should consider agreeing on a set of clear criteria for agenda-setting and formalising its use with the goal of empowering its Board officers to select the most strategic agenda items to be discussed at meetings. Some targets on the evolution of the number of agenda items over time should be set. The definition of the exact range is outside of the scope of this evaluation. However based on a review of the agendas of other global health organizations, a range of around 7 items per day is the norm, compared to 9.2 per day on average in 2013 for WHO. Given the fact that Member State interventions tend to extend the time spent on each agenda items, the 7 item benchmark should be considered as an upper limit. Alternatively a statistical analysis of the average time taken by agenda items presented to committees for decision, discussion, guidance and/or information could help in defining average anticipated duration of discussion on agenda items. These averages could be used as a starting point or sanity check on the reasonableness of draft agendas. Whilst this approach has obvious limitations, it can provide some bearings to limit the time spent on agenda items.
- **Adequate consultations on proposals for the management of agenda items, resolutions and the running of governing body meetings** prepared by the Secretariat should take place prior to their formal discussions in governing body meetings to ensure contradictory views are reconciled proactively (also refer to recommendation 9.3.5 on this point). Should Member States wish to take an even more active role in the definition of these rules of procedures, ultimately an intergovernmental working group could be setup to address the matter.

- **Committee Chairs should strive for more discipline during Member States interventions and monitor general behaviour at governing body meetings.** In doing so they should be supported by like-minded members and the Secretariat. This includes in particular:
 - **Discussing country health experiences outside of governing body meetings** to allow for in-depth strategic debates with Member States on the key common topics at stake. This will increase time spent on strategy. We endorse the suggestion from a Member State interviewee that an Appendix to governing body documentation be created to compile those country health experiences that Member States wish to bring to bear, without them being discussed in governing body interventions;
 - **The submission of late resolutions should be discouraged and rules and procedures of the WHA and EB on the matter be enforced.** The Organization should consider whether the introduction of proposals relating to agenda items 24h-36h prior to the start of governing body meetings is a sufficient time for submitting new draft resolutions (as the proposed recommendation of the Secretariat to amend rule 28 and 48-49 of the EB and WHA rules of procedures, respectively). In other international organisation governance settings, proposed agenda items are usually submitted to the Board, with documentation, at least 30-40 days prior to the governing body meeting, to allow for sufficient time for evaluation.

9.1.3. Organising for proper oversight of reform activities

Two elements relating to reform oversight and risk warrant attention.

First, there are some risks to the success of reform contained in the reform risk register that do not belong with the Secretariat such as:

- Deficit of clear mandate or willingness for EB, PBAC and RCs to execute defined roles
- Agenda to be discussed is too heavy/unwieldy
- EB does not reach consensus on proposed schedule change resulting in retaining current schedule of meetings of governing bodies

Whilst the Secretariat can bring these risks to bear to Member States, it is up to Member States to own these risks and define appropriate mitigations. **The Secretariat should make proposals on how these risks will be concretely reported to Member States and discussed, notably in terms of defining and executing mitigation strategies and accepting residual risks.**

Second, we note that a significant portion of the increase in agenda items and in PBAC and EB meeting is reform related. This is an unintended effect of reform which needs to be managed. The EB and PBAC should consider the following to:

- **Be more selective on the agenda items relating to reform** that are presented at PBAC and EB
- **Organise special sessions of the PBAC focusing solely on reform**, with the view to ensure proper consideration of reform agenda items and offloading of normal PBAC sessions in such a way that a manageable agenda is reached.
- **Extend the duration of PBAC meetings** to ensure sufficient time is dedicated to discuss reform items.

Third, the IEOAC has an important role to play in monitoring progress on reform, on a more regular basis, given that it meets three times a year, compared with the PBAC which meets bi-annually. The IEOAC should consider:

- **Reviewing regularly the reform risk register to identify areas where better risk management and more efficient risk mitigating activities can be developed throughout implementation of reform** and how it should be integrated into the overall corporate risk management framework;
- **Requesting detailed financial data from the RST to allow it to perform a thorough review of the reform budget utilisation** and advising on ways forward;
- **Providing in its annual reports to the PBAC, detailed evidence-based analysis and clear guidance to the PBAC on how to address reform-related risks** and deviations from the course of action of the reform.

Considering the rotation of IEOAC members at end of 2013, the Secretariat should consider **developing a reform induction pack** for new members including key documentation, tools and budget for new incoming members.

9.2. Recommendation # 2: Improve benefit management through a stronger theory of change of the reform

The monitoring framework and HLIP can be strengthened in such a way that they can better fulfil their role as a management and accountability tools. This strengthening can be based on the existing principles of using a theory of change and result-chain, complemented by some of the concepts on stages of transformation used in this evaluation.

9.2.1. Strengthen the results-chain for the reform

A theory of change for the reform that addresses the shortcomings identified in section 7.2.4 should be articulated.

The following **guiding principles should be followed**:

- Rebalance the focus from outputs and deliverables towards outcomes and impact of the reform, with a view to demonstrate the progressive realisation of benefits of the reform.
- Ensure relevant and logical linkages are understood and mapped, between outputs, outcomes and impact, but also between outcomes themselves.
- Ensure measurements are embedded throughout following the SMART principle, i.e. that they are specific, measurable now and in the future, achievable, realistic and time-bound.
- Provide a transparent and honest way to monitor and report progress at different levels of the organisation (Member States, Secretariat leadership, reform initiatives, regional level); progress should be understood to include both progress on activities and progressive realisation of the benefits expected from the reform.
- Ensure the framework enables communication with different audiences and supports effective decision-making by Governing body, Senior Management Team, RST and WHO staff.

Based on the above principles, two key areas require specific attention:

- **Ensuring that outputs and deliverables consider the whole lifecycle of change⁴⁷.** The lifecycle we used for the evaluation, from ‘Assess and Strategise’ to ‘Operate and Review’, is perfectly usable for this purpose. We recommend that for any output, a series of deliverables belonging to each stage of transformation are defined. This notably includes complementing the list of deliverables for the construct and implement stages, e.g. for training deliverables or roll-out activities. We also recommend that outputs remain relatively stable and changes be approved through a formal approval process involving at a minimum the GPG, with input from relevant ADGs where relevant, and possibly Member States, whilst changes to the list of deliverables be more flexible.
- **Thorough work on key performance indicators, notably through defining specific impact indicators demonstrating the benefit** of the reform for improved health outcomes, greater coherence in global health and an organisation that pursues excellence.

⁴⁷ 5 stages of transformation include: Assess and Strategise, Design, Construct, Implement, Operate and Review.

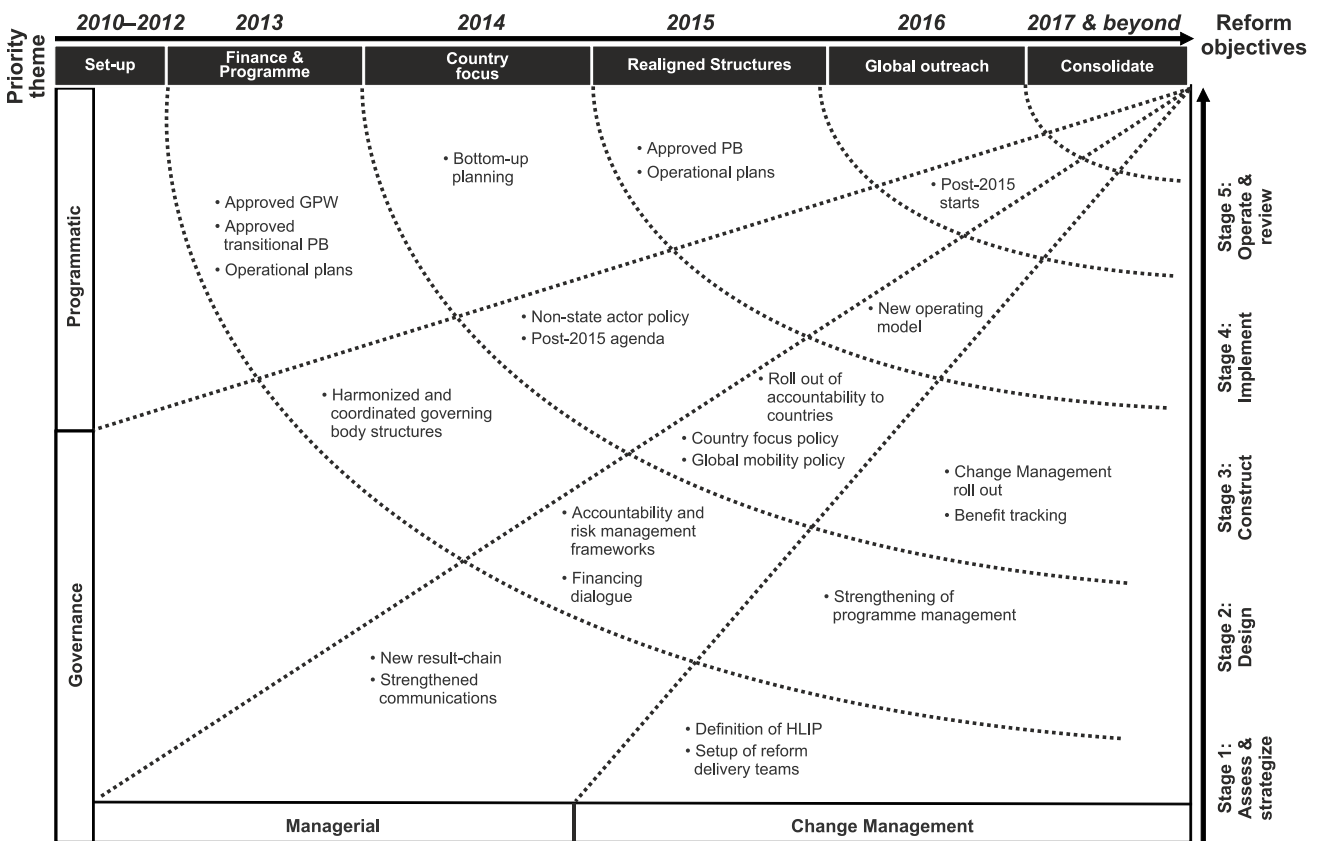
9.2.2. Reprioritise areas of focus

Based on the above, **the scheduling and progressive benefit realisation of the reform should be articulated.** This would allow to maintain momentum, provide the means for prioritising efforts and initiatives, and hold the Organization accountable for progress towards outcomes and impact.

This could take the form of an update to the reform HLIP and monitoring framework presented in May 2012 to the WHA (A65/INF.DOC./6).

This plan should outline the key achievements expected each year, and the priority initiatives to deliver against those.

An illustrative example is provided below, and would be for WHO to define:



This should then guide the attention given to respective initiatives and the degree of oversight exerted by governing bodies.

The prioritisation of initiatives should take into account:

- What it is important to do, i.e. those reform initiatives that deliver the most benefit should be given higher priority
- What it is possible to do, given the available resources and dependencies
- What is likely to succeed, i.e. priority should be given to areas where risks can best be managed and mitigated.

This could be achieved through the following simplified structured process:

- Determine the strategic alignment and value of reform outputs and deliverables with reform outcomes:
 - Review the package of reform initiatives based on the strengthened reform result-chain
 - Create one to three questions for each reform outcome or impact that serve as criteria to test the degree to which a particular reform initiative achieves desired outcomes
 - Develop a scoring model and test with a few initiatives. Ensure that the model equitably evaluates alignment with the reform objectives and objectively differentiates the initiatives. Score projects using the scoring model and rank initiatives in priority order.

The above could be prepared by the RST and refined through workshops with Business Owners, DPMs and DAFs.

- Determine the feasibility of the change based on resource requirements, risks and dependencies for each initiative, as outlined in recommendation 9.4.2 :
 - Determine internal and external resources required at all levels of the organisation to achieve desired results
 - Determine which initiatives need to be completed before or conducted in parallel for this initiative to be successful
 - Determine the risk of each initiative, the possible mitigation and the resulting residual risk ranking
 - Conclude the cost benefit analysis for each initiative and resulting priorities
- Approve and communicate the revised priorities across all levels of the organisation
 - Present the resulting prioritisation to key stakeholders, and ensure adoption by the GPG
 - Update the reform implementation plan and ensure buy-in from Member States
 - Circulate the information through the change and communication channels (refer to recommendation 9.3.2)
 - Establish an ongoing process to review the priorities

9.3. Recommendation # 3: Realign change and communication activities based on a thorough organisational impact assessment

The Secretariat's ability to drive and manage change is a key success factor for the operationalisation and institutionalisation of reform.

The recommendations contained in this section are not particularly innovative. They form, however, the basic set of actions that can be taken forward to address immediate change management needs.

Performing a thorough assessment of the desired and negative concrete impacts reform initiatives will have on various stakeholder groups will clarify the purpose of change and communication management activities. Given their importance in the upcoming phases of implementation and their limited engagement with reform to date, increased focus should be given to Technical Directors and WRs as key change agents. Finally, in order to mitigate some governance risks, innovative approaches to assisting Member States in the adaptation of their individual and collective behaviours should be considered.

9.3.1. Conduct an organisational impact assessment

The first step in adapting change, communication and risk management plans is to **articulate the impact of change in a crisper way**. Impact has a positive side in terms of the changes Member States and the Secretariat want to see, and a negative side in terms of the potential adverse consequences on some stakeholder groups, e.g. increased workload, discontinuation of activities, loss of status.

The starting point for this impact assessment is for the RST to **identify the stakeholders impacted by each reform initiative and by the overall reform process underway**. The stakeholders groups across the three levels of the organisation can be a starting base:

- HQ: ADGs, Reform Business Owners, Technical Directors, Technical & Programme staff, Admin staff
- RO: RD, DAF, DPM, Technical Directors, Technical & Programme staff, Admin staff
- CO: WR, NPOs, IPs, Admin staff

Also before starting the assessment, a classification of impacts in various dimensions should be defined. The suggestion below is a good starting point:

- Impacts on structure: including changes in organisational structure, shifts in responsibilities and accountabilities, cross-unit collaboration, increase or reduction in staff
- Impacts on roles: including new roles, additional or reduced activities, automation of manual activities
- Impact on skills and capabilities: including new competencies and capabilities needed, training required
- Impact on culture and behaviours: including change in behaviours, cultural impact, new objectives, metrics/performance measures

Based on the above, **the RST should organise workshops with Business Owners and their networks to document those impacts. The resulting should be consolidated into an impact assessment.**

This output should clearly articulate for each stakeholder group what is expected to start, to stop and to continue in their working practices, as well the potential unintended impact of reform initiatives on them.

9.3.2. Realign communication and change management plans

Based on this impact assessment the various change and communication interventions should be identified by the RST, in collaboration with BOs, DPM, DAFs and WRs.

The two major vehicles for change management should include notably adapted modes of communication and trainings on new policies, processes and systems or specific implementation approaches.

Specifically on communication, **care should be taken to move from a broadcast approach to one that is tailored to recipient needs**, based on the desired and anticipated impact of reform on these recipients. This involves working on both the content and channels used to deliver this message.

On the content side, a balance between communication on the process of reform and the impact and vision for reform should be sought. **Story-telling and concrete examples of how the reform is affecting the Organization and specific stakeholder groups should be developed.**

Regarding communication channels, a key element also relates to the ability of the Secretariat to provide line management and supervisors with relevant information that they can provide and discuss with their staff. **Business owners, supported by the RST, should develop and update regularly talking points for managers and supervisors on the specific initiatives.** Regular briefing sessions for supervisors should be organised.

9.3.3. Focus on WRs

WRs will play a critical role in implementing and institutionalising reform. First, they represent 61% of the 250 change agents identified across the Organization. Second, the true impact of reform will be achieved at country level. Third, they can leverage their close connections with Member States and other health players locally to effect improved coherence in global health. In order to enable them to be strong advocates and drivers of reform at national level, they need more engagement than the biannual global WR meetings or anecdotal involvement in some reform task forces.

Recommendations for furthering WRs' role and engagement on reform include to:

- **Equip WRs with key messages and talking points to be delivered to their respective Ministries of Health and external partners on the WHO reform.** This could take the form of using WHO's convening power at local level to present the orientation of the GPW and what this concretely means for WHO, Member States and other health actors at national level, notably in terms of priorities and complementarity. Some Member States interviewed suggested that doing so yearly on the World Health Day on 7 April could be a good opportunity.

- **Ensure Business Owners, DPMs and DAFs brief WRs more frequently and more in depth on the status, relevance and expected impact of reform on country offices should be implemented.** This could be done with more focus during regional meetings.
- **Empower WRs to support Member States to adapt their individual and collective behaviours during governing body meetings** (also refer to recommendation 9.1.2). They should have a proactive role in ‘sensing the pulse’ of Member States prior to governing bodies and in supporting them in the achievement of increased focus on strategic decision making. The initiative on strengthening support to Member States is an excellent vehicle to do so.
- **Consider creating a space and platform for inter-regional discussions among WRs, based on the model of the global health diplomacy course.** This could provide a forum to discuss how reform is implemented at country level and leverage good practices observed and find solutions to local situations that do not arise at HQ or regional level.

9.3.4. Focus on Directors

Technical Directors represent 16% of the change agent network and are the second largest group after WRs. Up to now, this group has not been considered as a real agent of change for the reform.

Given the nature of the reform package- largely focused on governance and managerial reforms- and the fact that the programmatic priority-setting, encompasses the development of the 12th GPW and PB 2014-15, little attention has been given the technical implementation of the programmes per se. Nonetheless, Directors are affected by the reform, notably through resource allocation shifts and their expectations and input into the reform need to be managed.

Our recommendations for furthering engagement of technical Directors, both at HQ and regional level, on reform include:

- **Involve technical Directors** in the concrete operationalisation of the PB 2014-15 and GMG/PRP to plan and organise their involvement in the operational planning process for 2016-17. We understand this is in progress.
- DG to **appoint technical Directors in taskforces** in general and ensure their full contribution.
- RST to **define accountability frameworks to implement the reform, where technical Directors are directly made responsible for concrete activities** and engaged in taskforces and working groups on reform.
- **Reform communication to provide specific material on reform to ADGs, DPMs and technical directors** in order to address their own concerns and also allow them to engage with their staff and address their questions.
- Consider **ensuring that in each cluster at least one “Go To” Director is appointed that plays a role in providing information** on those elements of reform relevant to their peers, e.g. during cluster

management meetings, and is solicited in defining key messaging on reform for staff, partners, donors and WHO Collaborating Centers.

9.3.5. Explore Innovative options to facilitate Member States individual and collective behavioural shifts

Up to now, no explicit change management activities have targeted directly Member States. The group is heterogeneous, from the point of view of the diversity of countries but also within country delegations, through the different perspectives of Foreign Ministry perspective of the Geneva missions and the Ministries of Health in capital.

Member States have been engaged in the reform process at varying levels depending on their roles in governing body or degree of interest in the reform process. The diversity of opinions is compounded by the rotation of Ministries of Health, which may shift national positions.

Since so much of the success of the programmatic and governance reform relies on Member States, the Secretariat should consider strengthening its change agent network for Member States. This change agent network cannot merely be Secretariat staff and management.

A requisite is to conduct a stakeholder mapping of Member States opinions and interests for those reform initiatives where Member States attitude directly drive success.

Based on this, proactive efforts in securing support and advocacy from those delegates that can positively influence the outcome of discussions, and addressing in advance of governing body meetings, e.g. via WRs, those concerns of delegates that can result in attitudes detrimental to the move to more strategic decision making for instance. This also involves that the Secretariat works in partnership with Member States to present well thought out, realistic solutions for consideration that take into account Member States sensitivities.

Change management could also leverage independent and trusted voices, such as those from retired experienced EB or RC members with depth and breadth of experience with the mechanisms of WHO's governing bodies. Such change agents can play a role to provide an outside-in voice, no longer attached to a country's specific interest. They can also offload Secretariat's management from heavy consultation processes on specific proposals. The appointment of the Special Envoy on the financing dialogue is a good example of such a mechanism.

9.4. Recommendation # 4: Strengthen reform Programme Management

Whilst the RST has been successful in taking the reform this far, strengthening its approach on programme management will be key to manage complexity as a number of reform initiatives move towards implementation.

The foundation for that strengthening relates to building capability in programme and project management. Only then can programme management practices be implemented in a reliable, continuous and risk-managed way.

9.4.1. Reinforce PM capacity of the Reform Support Team and BOs

Reinforcing programme management capability covers two aspects:

- **First, the Reform Support Team, Business Owners or their supporting staff should follow programme and project management training.** We recommend notably that the officers in the RST follow in depth training (e.g. practitioner level certification) whilst advisors and director follow a lighter one (e.g. foundation level). As part of this training, efforts should be made to ensure that a consensus is reached among the teams on how reform project management will be done moving forward. This notably includes training BOs and their teams in the newly defined project management tool.
- **Second, additional project managers should be on-boarded on reform initiatives.** At least one senior experienced programme manager should reinforce the RST, whilst business owners responsible for complex deliverables or outputs should be encouraged to budget for project management support in their 2014-15 plans. These resources could be redeployed from areas of the organisation which have a culture of project management (e.g. ITT) or sourced externally.

9.4.2. Re-engineer planning and budgeting processes

Based on the outcome of the recommendations contained in section 9.2, the RST and Business owners, in collaboration with their counterparts in regional offices, should **refine the plans underpinning each output and outcome.**

Care should be taken to ensure:

- Planning takes into account the whole scope of activities ('one-off' vs 'recurring' activities) needed to institutionalise the change, including notably expected activities at regional and country level, e.g. training, seminars or organisational changes.
- Dependencies within the initiative, with other reform initiatives or initiatives and events outside the reform are identified and documented.

This plan should then be the base for **BOs to define comprehensive and realistic budgets and operational plans defined for the 2014-15 period.** This involves more flexibility in budgeting for reform expenditure than for operational activities.

Whilst this process will be supported by the project management tool developed by the RST, care should be taken by the **RST to validate the relevance, pragmatism and comprehensiveness of the plans.**

Processes and systems should also be implemented to **ensure continuous and efficient monitoring of reform budget expenditure** is possible. This notably involves tracking reform related expenditures in GSM at a sufficient degree of granularity so as to enable automated reporting.

9.4.3. Fine tune reform management structures

Whilst the internal governance and management of reform is mainstreamed into WHO's management structures, we noted three areas of improvements that could improve the effectiveness of the internal steering on reform.

First, all members of the GPG interviewed have stressed how useful this forum is. Its success however relies on the ability of the Secretariat to ensure that the meetings of the GPG are well prepared, focus on key issues and that there is follow-up and implementation. To this end consistency in the following should be achieved to **strengthen the effectiveness of the GPG**:

- Agree a manageable agenda for the GPG with the RDs well in advance of the meeting
- Provide documents to be discussed at the GPG sufficiently in advance so that proper feedback can be provided
- Ensure that when the GPG discusses a policy related matter, the respective ADG is present to provide technical expertise
- Review key reform risks based on the reform risk register and if need be suggest additional mitigations
- Ensure coherence and consistency between reform activities taking place at global, regional and country level
- Ensure the GPG defines and agrees on key positions and messages that can then be communicated consistently and without ambiguity across the organisation, e.g. on the distribution of assessed and voluntary contributions or the ongoing nature of the financing dialogue
- Perform adequate follow-up to decisions taken by the GPG.

In order to perform the above, DGO should assess whether sufficient resources are dedicated to facilitating the work of the GPG.

Second, the articulation between the GPG and ADG groups should be improved. The initial meeting between the two groups should be institutionalised on a yearly basis, with reform as a key area of focus. This should be the occasion to stock take on key reform initiatives which success lie in the proper articulation between RDs and ADGs, such as Category Networks, implementation of reform at regional and country level, operating model or technical planning.

Third, the coordination between Business Owners should move from bilateral discussions between a BO and the RST or two BOs, to managing BOs as a group, through a dedicated quarterly or bi-annual meeting. This could be done shortly before or after each EB meeting. The agenda of such meetings could include:

- Review of progress, successes and challenges. This would include the identification of common patterns to be addressed by BOs and feedback to RST team on the support required until the upcoming governing body meeting.
- Pulse survey: where a staff survey on reform has been completed, the results and actions from this survey should be discussed and remedial actions agreed. Where no survey is available, assessing staff pulse on reform should be based on discussions and feedback from BOs.
- The outlook on upcoming short and medium term reform activities in terms of stakeholders impacted, dependencies and risks should be performed jointly by BOs. Seeking agreement on remedial and communication actions is recommended.
- Agreement on talking points to be provided to ADGs, Directors, DPMs, DAFs and WRs.

Fourth, the DPM and DAF networks should be better leveraged to organise, plan and roll-out reform implementation at regional and country level. WRs should be fully involved in the process. Lead WRs in regions could be selected to represent sub-regional groupings of WRs and be involved in regional office discussions on reform with their respective RD, DPM and DAF, through the DPM or DAF networks, or management meetings. These lead WRs could then play the role of change agents with other WRs, notably through the platform of communication between WRs suggested in section 9.3.3 above or quarterly meetings of these sub-regional groupings of WCO to discuss reform-related matters and share best practices. These discussions would be attended members of the RST.

9.4.4. Institute regular quality assurance and evaluation mechanisms on reform

Stage 1 and 2 evaluations have provided a valuable additional perspective on the issues facing the Secretariat in implementing reform, and an external challenge to the robustness of plans and processes.

As the RST, BOs and their regional counterparts focus on delivery, there is a need to provide:

- Adequate quality assurance and formative evaluations over reform activities and deliverables for continuous improvement purposes. Options could be to **perform an annual independent evaluation of reform or as an alternative, to implement a continuous quality assurance process**, e.g. monthly, quarterly or bi-annually. We favour this latter approach as it would provide more timely feedback to the internal teams and recommend reporting on a monthly or quarterly basis.
- Summative evaluations focusing on **evaluating whether the intended results are achieved and inform strategy setting should be towards the end of each biennium**. They should be closely related to the priority setting and monitoring framework outlined in the recommendations contained in section 9.2

Care should be taken to ensure these processes do not place an unnecessary burden on the Organization’s time and focus.

Also given the pervasive nature of the WHO reform, we believe this quality assurance function would be best performed by an external party such as:

- The JIU
- A “peer review” similar to what the UK government has implemented with their Gateway review process where a senior civil servant performs this role for another organisation. This means that this role could be performed by a group of representatives of Member States or by senior staff from another UN agency which have assisted in previous complex or UN reforms.
- A commercial firm with expertise in complex transformations.

The **GPG and EB should agree on the terms of reference for such reviews**, which should cover both the substance and process of reform.

Also the role and focus of the IEOAC in providing oversight over reform activities should be strengthened through:

- **Articulating clearly those areas where the IEOAC can add value in oversight** of reform activities, e.g. in monitoring the reform risk management and financials, as opposed to other areas (e.g., change management).
- **Ensuring specific, relevant and timely input and reports are provided to the IEOAC** so it can fulfil its function.

9.4.5. Implement ongoing reporting

A key focus of project management should be on ensuring adequate monitoring and reporting of reform at all levels of the organisation.

As a principle, monitoring and reporting should cover:

- Delivery of benefits through the tracking of outcome and impact indicators;
- Status and progress on reform activities through the tracking of outputs and deliverables;
- Expenditures, e.g. budget vs actual expenditures on reform;
- Risks, including changes in mitigations and residual risks.

With the implementation of the reform project management tool, the on-boarding of additional reform project managers and the roles played by the BOs and GPG meetings, **reporting can be turned from being event driven to a regular monthly process.**

Experience shows that to succeed, the added burden of reporting on staff and management's time needs to be offset by the value they see in the information that is returned to them.

In this respect the **reporting on reform should be tailored for each of the following audiences:**

- RST: overall consolidated detailed reporting to Member States
- BOs should get: detailed reporting for their initiatives from the regional and country levels
- RDs should get: overall and consolidated reporting for their region from DPM, DAFs and WRs
- EB and PBAC should get: overall summary reporting from RST
- IEOAC should get: overall consolidated risk and financial reporting from RST

In order to avoid duplication of tasks and unnecessary overhead, attention should be paid to ensure all the relevant and only the relevant information is captured in the project management tool. Putting in place such a reporting system, will allow for more regular and reliable reporting and will reinforce mutual accountabilities of all parties on making the reform a success.

If implemented in a comprehensive manner and according to the proposed schedule presented in the Executive Summary, these recommendations will go a long way in supporting, enabling and accelerating the implementation of the reform process and mitigating most of the barriers to change identified in the evaluation.