World Health Organization

EXECUTIVE BOARD
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Programme budget 2020–2021

WHO results framework: an update

Report by the Director-General

1. In resolution WHA72.1 of 24 May 2019, the Seventy-second World Health Assembly approved the Programme budget 2020–2021 and requested the Director-General, inter alia, to continue developing the results framework of the Thirteenth General Programme of Work, 2019–2023 (GPW 13), in consultation with Member States, including through the regional committees, and to present the results framework to the Executive Board at its 146th session.

2. The GPW 13 focuses on measurable impacts on people's health at the country level. In order to implement this measurement system, a results framework is required to regularly track the joint efforts of the Secretariat, Member States and partners to meet GPW 13 targets and achieve the Sustainable Development Goals (SDGs), as well as to measure the Secretariat's contribution to that process. In addition, the 2017–2018 assessment of WHO by the Multilateral Organisation Performance Assessment Network, in keeping with the increased impact- and outcome-focused approach of the GPW 13, stated that an accurate and reasonable measurement of WHO's contribution is needed, and that there needs to be clarity on what is being tracked and measured.[1]

3. The results framework presented in this document (see Annex 1) is accompanied by a system for measuring impact – the GPW 13 WHO Impact Framework;[2] a scorecard for output measurement (see Annex 5, document EB146/28 Add.1); and qualitative case studies. Together, they provide a holistic view of WHO's overall impact. WHO' GPW 13 impact measurement structure (see Annex 2) consists of the top-level indicator of healthy life expectancy (HALE); the triple billion targets and related indices (see Annex 3); and 46 outcome indicators (see Annex 4).

4. The time frame for the results framework is 2019–2023 and spans three separate programme budget periods: the end of the biennium 2018–2019, the biennium 2020–2021 (for which the programme budget was approved in May 2019) and the biennium 2022–2023.

5. Pursuant to resolution WHA72.1, this document summarizes the plans for the elaboration of the methods for calculating the outcome indicators, the triple billion indices and HALE, which will be subsequently issued as a methods report, as well as plans for the finalization of the Output Scorecard. The updated process has incorporated Member States' feedback through the six regional committee

[1] Multilateral Organisation Performance Assessment Network (MOPAN). MOPAN 2017-18 assessments: World Health Organization (WHO). April 2019 (http://www.mopanonline.org/assessments/who2017-18/, accessed 18 November 2019).

[2] See document A72/5.

meetings. In addition, a technical consultation, including experts from Member States and academia, has provided inputs to refine the methods of impact measurement.

Outcome indicators

6. The outcome indicators are intended to provide a flexible approach in which Member States select their own priorities. Countries will therefore be able to target their efforts according to their specific local health needs. Countries will track progress using the associated outcome indicators.

7. Annex 4 provides a full list of the proposed 46 outcome indicators, 39 of which are SDG indicators; the seven non-SDG indicators, which were approved in World Health Assembly resolutions and have been selected for GPW 13, cover antimicrobial resistance (antibiotic consumption); polio; risk factors for noncommunicable diseases (obesity; blood pressure; trans-fatty acids); and emergency-related factors (vaccination for emergencies, essential health services for vulnerable populations).

Universal health coverage index

8. A combined measure of health service coverage and related financial hardship will be used to monitor progress towards the GPW 13 milestones. Health service coverage will continue to be measured using the service coverage index that has been approved by the Inter-agency and Expert Group on SDG indicators (IAEG-SDGs). The methodology to create the index, related to indicator 3.8.1 of the SDGs, is well documented and involves a simple aggregation method.[1]

9. Financial hardship due to spending on health occurs when a household has to pay a very large share of its disposable income on health services (catastrophic payments) or when the costs of health services push a household below the poverty line (impoverishing payments). The methodology to estimate financial hardship related to indicator 3.8.2 of the SDGs is also approved by the IAEG-SDGs and documented.[1]

10. Member States, the Secretariat, United Nations partners and the IAEG-SDGs all recognize that the current measure of health service coverage focuses on "crude" coverage and does not capture "effective" coverage, that is, whether people who need health services are receiving services of sufficient quality to produce the desired health gain. The Secretariat has begun work on an updated index that categorizes tracer indicators by type of care (promotion, prevention, treatment, rehabilitation and palliation) and by age group (life course). The Secretariat has convened a meeting of representatives of Member States, experts and United Nations partners to finalize the methodological work related to the updated index.

Health emergencies protection index

11. The health emergencies protection index consists of three tracer indicators, derived from the outcome indicators, that capture activities to prepare for, prevent, and detect and respond to health emergencies. This index is the mean value of the indicators of the capacity to prepare, prevent, and detect and respond.

[1] See the metadata repository of the United Nations Statistics Division (https://unstats.un.org/sdgs/metadata/files/Metadata-03-08-01.pdf, accessed 18 November 2019).

Healthier population index

12. The healthier population index focuses on measuring the impact of multisectoral interventions that are influenced by policy, advocacy and regulatory approaches stewarded by the health sector. The priority indicators for use in this index are in the process of being selected from the outcome indicators.

Healthy life expectancy

13. HALE is a comprehensive summary measure of population health that combines the measurement of lifespan and health span. It is the mean number of years that a person is expected to live in good health, accounting for years lived in less than full health due to disease or injury. WHO regularly reports on HALE through its global health estimates, using an accepted standard methodology.

Methods

14. A methodology document that is regularly updated has been made available online, along with baselines and targets for the triple billion indices and the outcome indicators. The methodology document also includes suggested approaches to data disaggregation for the outcome indicators and the triple billion indices in order to enable inequality monitoring so as to determine who is being left behind.

15. Refinements to the methodology and steps to improve data availability for the health emergencies protection index, especially for the detect and respond indicator, were made over the course of 2019. Member States were consulted in the process of finalizing the methodology.

16. The method for the calculation of the healthier population 1 billion target was developed by a working group in the Secretariat, which discussed and addressed methodological issues. The proposed methodology was reviewed in a consultation with representatives of Member States and experts held in October 2019.

17. Other public health priorities for which additional milestones and indicators are being considered include service coverage for severe mental disorders, care dependency in older adults, cervical cancer screening and palliative care. The Secretariat will continue to engage with Member States and experts over the course of 2019–2021 in defining the indicators for these areas, exploring ways of strengthening data sources and finalizing methodology through a series of technical consultations. Baselines and milestones will be established once these steps have been completed. The indicators that are agreed on will then be presented to the Executive Board for inclusion in the proposed programme budget for 2022–2023.

Output measurement

18. The Secretariat is making a significant shift in its approach to measuring its accountability for results, from a top-down aggregate approach to one that measures the Secretariat's impact at the country level. The Secretariat will measure the delivery of outputs as a way of demonstrating its contribution to the achievement of outcomes and to the impact in each country. The integrated nature of the results framework – in particular of the outputs – calls for an innovative way of measuring the outputs to promote accountability and a more meaningful measurement of Secretariat delivery. To this end, the Secretariat is proposing a new approach to measuring the outputs: it will no longer identify a large number of output indicators, since that approach has proved to be insufficient to ensure transparency and accountability and the indicators have succeeded in measuring only part of the results achieved by the outputs.

19. The new approach to output measurement adopts a scorecard approach (see Annex 5, document EB146/28 Add.1). The new approach is an important step forward to strengthen how performance is measured in WHO. The aim is to introduce an output assessment system which is more:

- **meaningful:** by being focused more directly on strategic priorities and the work that the Secretariat is actually doing;
- **accountable:** by providing clear linkages to what is expected under each output and from each budget centre;
- **holistic:** by covering different aspects of performance rather than the current unidimensional approach using multiple indicators.

20. The new approach draws on experience elsewhere, including the use of balanced scorecards for strategic management and performance assessment in large organizations. By adopting this approach, the Secretariat is proposing to measure the depth and breadth of each output using six assessment parameters or dimensions, which have been chosen to relate directly to what is strategically important for WHO across all of its work.

21. The first three dimensions assess the strategic shifts intended in GPW 13 that define WHO's effective delivery: (a) how well the Secretariat has performed its leadership function at all levels; (b) the extent to which the Secretariat has delivered the priority global goods that are critical to achieving the output; and (c) the extent to which the Secretariat has delivered technical support to achieve impacts in countries.

22. The assessment of the fourth and fifth dimensions demonstrates WHO's commitment to mainstream interventions that achieve outputs while integrating gender, equity and human rights and to deliver interventions that provide value for money.

23. The sixth dimension – achieving results in ways leading to impacts – ensures the proper tracking of the influence of WHO's work to ensure the achievement of outcomes and impacts in countries. By tracking the early indications of success (leading indicators), the Secretariat will be able to demonstrate accountability not only for delivering outputs but also for contributing to the outcomes and impacts that matter most.

The elements of the Output Scorecard

24. The Output Scorecard structures the assessment of performance holistically, using three steps.

- Performance is defined and structured around six key dimensions of performance that reflect what is strategically important for WHO.
- Performance is assessed for each dimension with a set of performance attributes that lay out clear expectations for delivery by the Secretariat (e.g. "Is the Secretariat providing strategic and authoritative advice on health matters?" or "Is the Secretariat delivering the global public health goods that are critical to delivering the outputs?"). These attributes define clearly exactly what is being measured under each dimension.
- Each attribute is scored using a 4-point scale, using a common set of criteria across the outputs. A scale with a detailed explanation of the range of ratings is provided to ensure a more objective

measurement of the attribute. The average score of the attributes under each dimension defines the score for that dimension.

25. The Output Scorecard, with the full set of six dimensions with its attributes, criteria and scoring scale, is presented in Annex 5 (document EB146/28 Add.1). Annex 5 also elaborates on the leading indicators by which the "Results in ways leading to impact" dimension will be measured.

26. The approach to selecting leading indicators also represents a change in the way in which the indicators will be used to measure performance. The output delivery teams, an internal platform for collaboration across departments and programmes, have been developing a logic model, or theory of change, for each output. The purpose is to analyse how the Secretariat's work leads to the delivery of the outputs, and then how the delivery of outputs influences the achievement of outcomes and impacts. From this, a set of the most critical leading indicators that allow the Secretariat to track its influence to outcomes and impacts will be selected.

27. This first iteration of the leading indicators will be tested and developed further as part of the pre-testing for the entire Output Scorecard during early 2020. Further work will be done to assess whether these suggested indicators meet the criteria outlined above and where additional development and testing work is needed, and alternatives will be explored. Logic models will be tested and determination made as to whether the indicators represent the influence of WHO across the three levels to achieving outcomes/impacts. Some of these indicators may be refined or replaced before full roll-out of the Output Scorecard.

Method of assessment and validation

28. The assessment will be initiated by teams at all levels of the Organization. They will rate their performance against the attributes under each dimension for each output using a set of criteria with the scoring scale. Certain dimensions may be assessed through internal peer validation.

29. The self-assessment ratings will be validated by a three-level mechanism described as follows:

(a) Internal moderation of ratings – line managers check for quality and consistency of ratings across different entities. Output delivery teams from every major office, and the global output delivery teams, will also review the ratings under their respective outputs.

(b) Internal peer review combined with sample expert check of rating – mechanisms such as validating the high self-assessment ratings (ratings of 4). This process will be led by a small group of staff who have expertise in the specific dimension.

(c) Periodic validation check – using independent validation or spot checking, for example through the programmatic audits of WHO's Internal Oversight Services or periodic evaluations.

Consultations and finalization of the Output Scorecard

30. The Output Scorecard methodology represents an important change in WHO that will require understanding and the buy-in of the staff who will apply the Output Scorecard.

31. The work on the presentation of the concept of the Output Scorecard to WHO has centred on testing the idea and developing the measurement instrument to make sure that it is robust and credible yet simple enough to be put into practice immediately in the 2020–2021 biennium.

32. Several internal consultations with staff across the three levels of the Organization have been conducted, while the inputs of staff members at all three levels of the Organization have shaped the measurement instrument in a way that is relevant to measuring their work.

33. The Output Scorecard has been refined based on consultations and initial pilot testing at headquarters, regional offices and country offices. Further pilot testing is under way and could lead to further refinements of the proposed attributes, criteria, scale and indicators. Opportunities to observe the pilot testing will be made available to Member States in order to enhance their understanding of the methodology and plans for implementation of the Output Scorecard.

Reporting results

34. The reporting of results by the Organization will also change significantly in order to strengthen its accountability for delivering results.

35. The change will start in the process of generating and monitoring data and information across the Organization. The objective is to strengthen the linkages between country offices, regional offices and headquarters so that the information generated from monitoring not only informs reporting globally but also ensures learning and provides feedback to the implementation process, ensuring a clearer focus on the delivery of outcomes and the triple billion targets across the Organization.

36. This new approach will require better linkages within the major offices and coordination across the three levels of the Organization. The Secretariat will use its newly established networks and teams for joint delivery and monitoring across the Organization.[1]

37. The reporting will also change by harmonizing previously fragmented data, such as WHO statistics, WHO observatory reports, programme review reports, country reports and corporate results reporting. The aim is to strengthen the coherence of the reports by using the same data and sources and aligning them with the new measurement system for GPW 13.

38. The results report to Member States will be prepared annually, based on the GPW 13 results framework, which will progressively include all aspects of the new reporting structure, including reporting on the Output Scorecard, the outcomes and the triple billion targets. The results report for the biennium 2020–2021 will contain a scorecard for each of the outputs and the performance of output delivery at each of the levels of the Organization. It will include both quantitative reports on the indicators and indices and qualitative reports that explain progress, risks, challenges and lessons learned, as well as case studies that illustrate the impacts resulting from WHO's work in countries and from its normative functions.

39. At the end of the GPW 13 period, the Secretariat will prepare a comprehensive report summarizing progress made towards the GPW 13 2023 targets, the triple billion targets and the Secretariat's contribution as measured through the Output Scorecard and the qualitative case studies over the 2019–2023 period.

[1] WHO has established output delivery teams, outcome networks and strategic priority networks to ensure coherence in planning, monitoring and reporting, and joint delivery of the Secretariat's work in line with the integrated results framework. The aim is to work in a coordinated way to achieve the triple billion targets. See Annex 5 (document EB146/28 Add.1) for further details.

40. Selective country case studies will showcase the Organization's impact by sharing experiences on successes and lessons learned, including failures, strengthening its role as a learning organization. Case studies at the country, regional or global levels may be included and clear country results will be demonstrated, as well as the impact of WHO's work on the lives of people.

Next steps

41. The Secretariat will continue to work with Member States, national statistical offices and other partners in order to empower countries to analyse, interpret and track progress and thus make maximal use of their data as they advance towards meeting the pledge of the 2030 Agenda for Sustainable Development to leave no one behind.

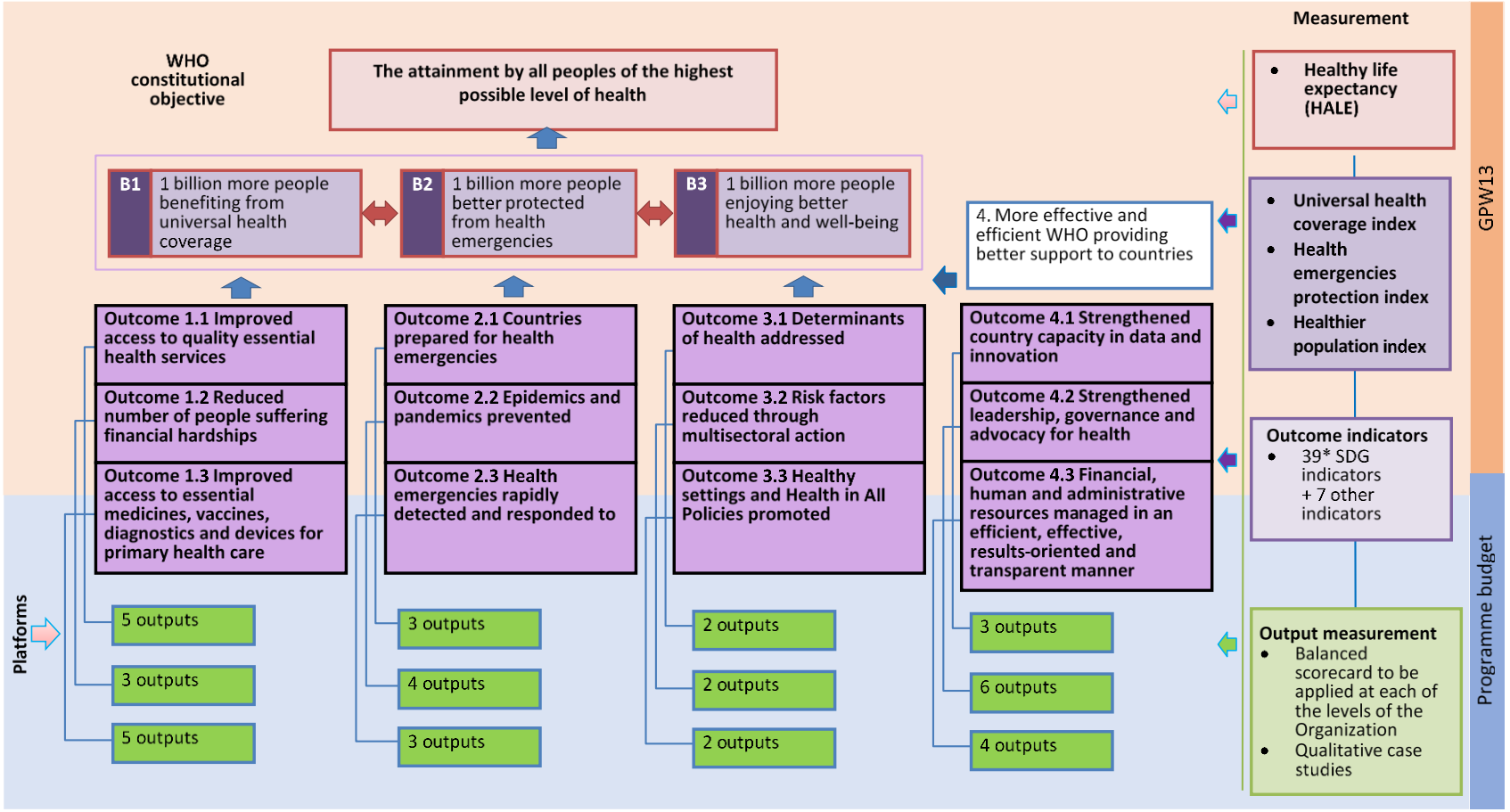
42. The Secretariat will work with all its offices to refine further the Output Scorecard instrument in order to ensure a balance between robustness and credibility on the one hand and simplicity and feasibility of application on the other. Member States will be consulted before its finalization and presentation to the World Health Assembly.

ACTION BY THE EXECUTIVE BOARD

43. The Executive Board is invited to note the report and comment and provide strategic advice on the finalization of the measurement of the results framework. This will inform the text of the document that will be submitted for consideration by the Seventy-third World Health Assembly.

ANNEX 1

THIRTEENTH GENERAL PROGRAMME OF WORK, 2019–2023: RESULTS FRAMEWORK

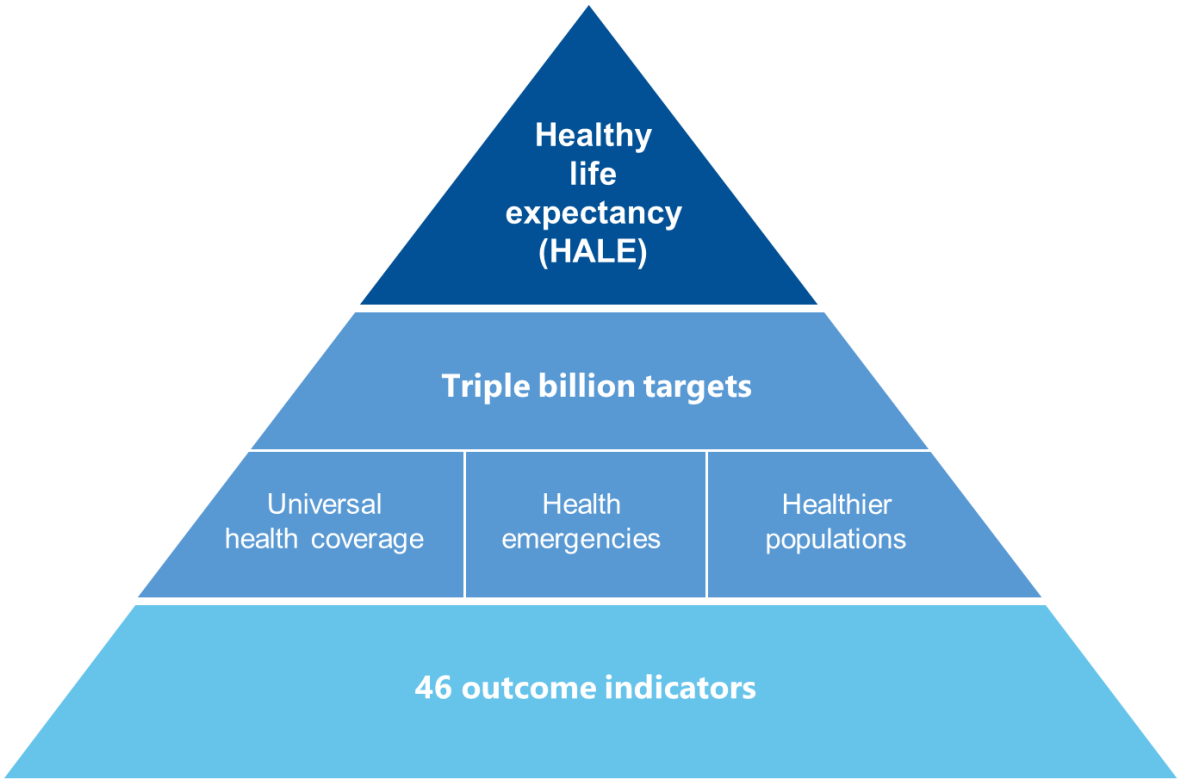


* Changed from 38 to 39 as the antimicrobial resistance indicator will be formally included in SDG list of indicators following the 2020 Comprehensive Review.

GPW 13: Thirteenth General Programme of Work, 2019–2023; SDG: Sustainable Development Goal.

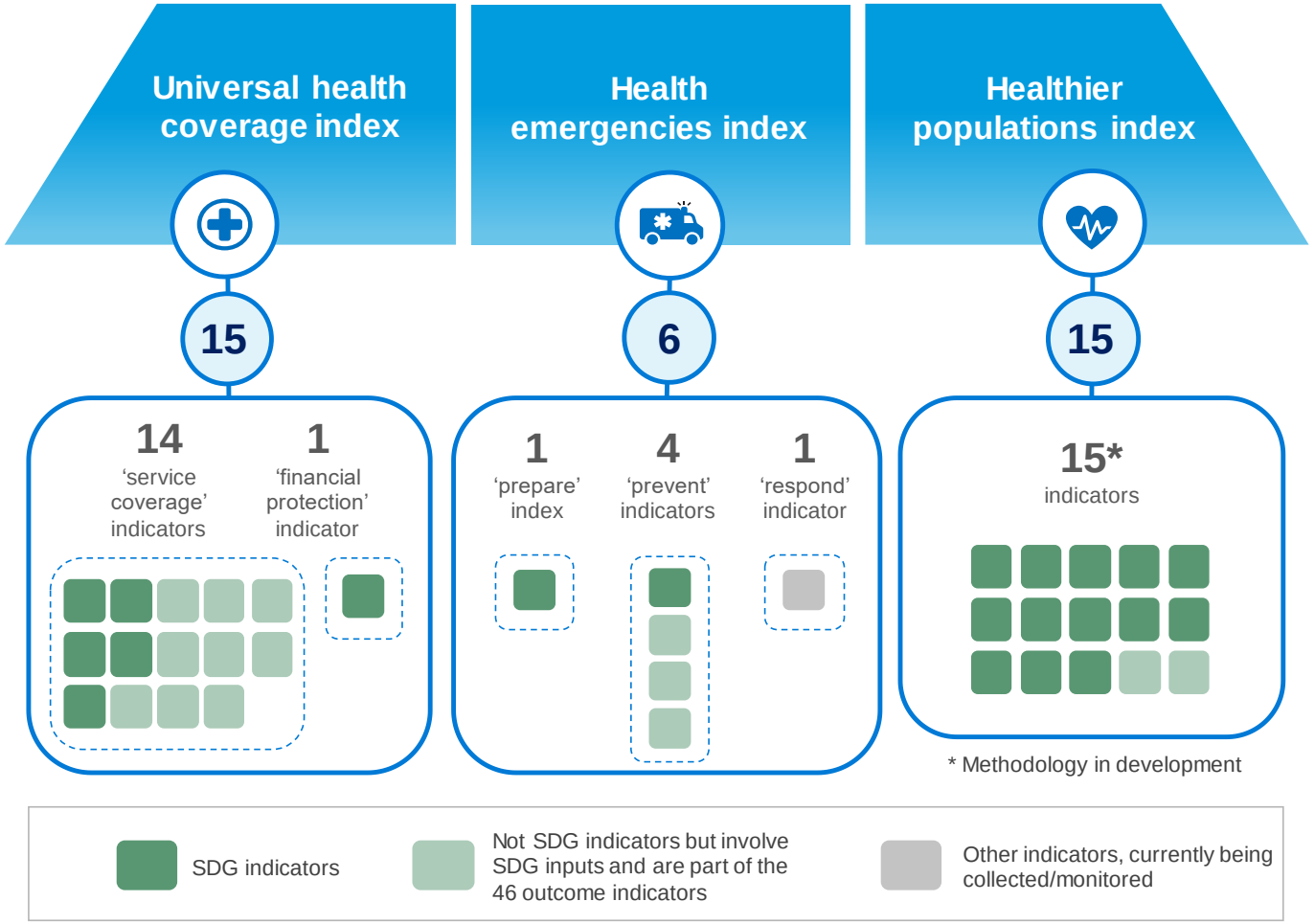
ANNEX 2

WHO'S GPW 13 IMPACT MEASUREMENT STRUCTURE



ANNEX 3

TRIPLE BILLION TARGETS AND RELATED INDICES: MAPPING WITH SDG INDICATORS



ANNEX 4

MAPPING 2023 TARGETS OF GPW 13 TO SDG/ HEALTH ASSEMBLY INDICATORS

Number of SDG indicator/ Health Assembly resolution	**SDG/Health Assembly indicator**	**2023 target of GPW 13**
SDG 1.5.1	Number of deaths, missing persons and directly affected persons attributed to disasters per 100 000 population	Reduce the number of deaths, missing persons and directly affected persons attributed to disasters per 100 000 population
SDG 1.a.2	Proportion of total government spending on essential services (education, health and social protection)	Increase the share of public spending on health by 10%
SDG 2.2.1	Prevalence of stunting (height for age <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age	Reduce the number of stunted children under 5 years of age by 30%
SDG 2.2.2	Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age (wasting)	Reduce the prevalence of wasting among children under 5 years of age to less than 5%
SDG 2.2.2	Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age (overweight)	Halt and begin to reverse the rise in childhood overweight (0–4 years)
SDG 3.1.1	Maternal mortality ratio	Reduce the global maternal mortality ratio by 30%
SDG 3.1.2	Proportion of births attended by skilled health personnel	
SDG 3.2.1	Under-5 mortality rate	Reduce the preventable deaths of newborns and children under 5 years of age by 17% and 30%, respectively
SDG 3.2.2	Neonatal mortality rate	
SDG 3.3.1	Number of new HIV infections per 1000 uninfected population, by sex, age and key populations	Reduce the number of new HIV infections per 000 uninfected population, by sex, age and key populations, by 73%
SDG 3.3.2	Tuberculosis incidence per 100 000 population	Reduce by 27% the number of new tuberculosis cases per 100 000 population
SDG 3.3.3	Malaria incidence per 1000 population	Reduce malaria case incidence by 50%
SDG 3.3.4	Hepatitis B incidence per 100 000 population	Reduce hepatitis B incidence to 0.5% for children under 5 years
SDG 3.3.5	Number of people requiring interventions against neglected tropical diseases	Reduce the number of people requiring interventions by 400 million

Number of SDG indicator/ Health Assembly resolution	SDG/Health Assembly indicator	2023 target of GPW 13
SDG 3.4.1	Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease	Achieve 20% relative reduction in the premature mortality rate (age 30–70 years) attributed to noncommunicable diseases (cardiovascular, cancer, diabetes or chronic respiratory diseases) through prevention and treatment
SDG 3.4.2	Suicide mortality rate	Reduce suicide mortality rate by 15%
SDG 3.5.1	Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders	Increase service coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders
SDG 3.5.2	Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol	Achieve 7% relative reduction in the harmful use of alcohol, as appropriate, within the national context
SDG 3.6.1	Death rate due to road traffic injuries	Reduce the number of global deaths and injuries from road traffic accidents by 20%
SDG 3.7.1	Proportion of women of reproductive age (15–49 years) who have their need for family planning satisfied with modern methods	Increase to 66% the proportion of women of reproductive age (15–49 years) who have their need for family planning satisfied with modern methods
SDG 3.8.1	Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)	Increase coverage of essential health services
SDG 3.8.2	Proportion of population with large household expenditures on health as a share of total household expenditures or income	Halt the rise in the proportion of people who suffer financial hardship (defined as out-of-pocket spending that exceeds ability to pay) in order to access health services
SDG 3.9.1	Mortality rate attributed to household and ambient air pollution	Reduce the number of deaths and illnesses attributed to hazardous chemicals and air, water and soil pollution and contamination
SDG 3.9.2	Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services)	
SDG 3.9.3	Mortality rate attributed to unintentional poisoning	

Number of SDG indicator/ Health Assembly resolution	SDG/Health Assembly indicator	2023 target of GPW 13
SDG 7.1.2	Proportion of population with primary reliance on clean fuels and technology	
SDG 11.6.2	Annual mean levels of fine particulate matter (e.g. PM2.5 and PM10) in cities (population weighted)	
SDG 3.a.1	Age-standardized prevalence of current tobacco use among persons aged 15 years and older	Achieve 25% relative reduction in prevalence of current tobacco use in persons aged 15 years and older
SDG 3.b.1	Proportion of the target population covered by all vaccines included in their national programme	Increase coverage of second dose of measles-containing vaccine to 85%
SDG 3.b.3	Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis	Increase the availability of essential medicines for primary health care, including those free of charge, to 80%
SDG 3.c.1	Health worker density and distribution	Increase health workforce density, with improved distribution
SDG 3.d.1	International Health Regulations (IHR) capacity and health emergency preparedness	Increase Member States' IHR capacities
SDG 3.d.2	Percentage of bloodstream infections due to selected antimicrobial-resistant organisms	Reduce by 10% the percentage of bloodstream infections due to selected antimicrobial-resistant organisms
SDG 4.2.1	Proportion of children under 5 years of age who are developmentally on track in health, learning and psychosocial well-being, by sex	Increase to 80% the proportion of children under 5 years of age who are developmentally on track in health, learning and psychosocial well-being
SDG 5.2.1	Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age	Decrease from 20% to 15% the proportion of ever-partnered women and girls aged 15–49 years subjected to physical or sexual violence by a current or former intimate partner in the previous 12 months
SDG 5.6.1	Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care	Increase to 68% the proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care
SDG 6.1.1	Proportion of population using safely managed drinking water services	Provide access to safely managed drinking water services for 1 billion more people
SDG 6.2.1	Proportion of population using (a) safely managed sanitation services and (b) a hand-washing facility with soap and water	Provide access to safely managed sanitation services for 800 million more people
SDG 16.2.1	Proportion of children aged 1–17 years who experienced any physical punishment and/or psychological aggression by caregivers in the past month	Decrease by 20% the proportion of children subjected to violence in the past 12 months, including physical and psychological violence by caregivers in the past month

Number of SDG indicator/ Health Assembly resolution	**SDG/Health Assembly indicator**	**2023 target of GPW 13**
Health Assembly resolutions on health emergencies	Vaccine coverage of at-risk groups for epidemic or pandemic prone diseases	Increase immunization coverage for cholera, yellow fever, meningococcal meningitis and pandemic influenza
Health Assembly resolutions on health emergencies	Proportion of vulnerable people in fragile settings provided with essential health services	Increase to at least 80% the proportion of people in fragile, conflict or vulnerable settings with access to health facilities providing a minimum services package
WHA68.3 (2015)	Number of cases of poliomyelitis caused by wild poliovirus	Eradicate poliomyelitis: reduce to zero the number of cases of poliomyelitis caused by wild poliovirus and establish a clear timetable for the global withdrawal of oral polio vaccines in order to stop outbreaks caused by vaccine-derived poliovirus
WHA68.7 (2015)	Patterns of antibiotic consumption at the national level	Increase the share of Access Group antibiotics to ≥60% of overall antibiotic consumption
WHA66.10 (2013)	Age-standardized prevalence of raised blood pressure among persons aged 18+ years (defined as systolic blood pressure of >140 mmHg and/or diastolic blood pressure >90 mmHg) and mean systolic blood pressure	Achieve a 20% relative reduction in the prevalence of raised blood pressure
WHA66.10	Percentage of people protected by effective regulation on *trans*-fats	Eliminate industrially produced trans-fats (increase the percentage of people protected by effective regulation)
WHA66.10	Prevalence of obesity	Halt and begin to reverse the rise in obesity

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