Handbook

for the induction of Heads of WHO Offices in countries, territories and areas.

Geneva
March 2015
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Introduction

One of the cornerstones of the WHO reform process is to improve organizational effectiveness and performance at country level. To realize this goal, Heads of WHO Offices in countries, territories and areas (HWOs) need to be empowered with the necessary diplomatic, political, technical and managerial competencies to excel in their functions. This handbook is designed to provide HWOs with relevant, hands-on messages on a series of key topics to help them in their day-to-day tasks at country level.

The first version of this Handbook was produced in 2014 and was made available to both newly-appointed and long-serving HWOs. The content was prepared based on a comprehensive mapping of the topics covered during briefings at the regional and global levels, on administrative and managerial topics that were identified as pivotal to everyday work in country offices.

Since 2014, the Organization has continued the process of implementing the reforms. One result has been the creation of a new, standardized post description for HWOs, to ensure the right profile for the important function. The post description, which was agreed throughout the Organization and published as a vacancy notice, reflects the necessary technical and managerial competencies for HWOs. The three key functional areas in which HWOs should excel, which are mirrored in the organization of this Handbook, are as follows:

1. Convening, representation, partnership and advocacy
2. Technical cooperation, policy advice and dialogue
3. Administration and management

Based on the feedback of HWOs, as well as extensive discussions with technical counterparts throughout the organization and the regional Country Support Unit Network, it was decided to expand the content of the Handbook. In addition to administrative and managerial issues, this year’s Handbook will also include information on technical topics that are part of the six WHO leadership priorities but in which country offices may be lacking in capacity.

The content of each chapter was prepared by the relevant technical unit in Headquarters, with guidance and support from the Department of Country Cooperation and Collaboration with the United Nations System (CCU). The information in the Handbook is designed to complement and supplement the material presented during the Global Induction of HWOs, and provides sufficient resources at the end of each chapter should HWOs like to know more details on the topic.

Like the work of the entire Organization, the content of the Handbook is always changing. As a result, it is updated annually in the lead-up to the yearly Global Induction of HWOs, especially to include strategic policy decisions that have implications at the country level. The Handbook is also available online – with live links – to allow for easy access at all times.

It is the hope of the entire Organization that this Handbook will provide useful and relevant information to aid HWOs in their important work at country level. We look forward to your guidance and feedback, and welcome any suggestions for supplemental material. Please contact CCU by emailing countryfocus@who.int.

Dr Shambhu Acharya
Director (a.i), CCU
Geneva, Switzerland
March 2015
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Part I
Convening, representation, partnership and advocacy
The post-2015 development agenda and the Sustainable Development Goals

Background

The aim of this chapter is to ensure that all HWOs are informed on the current state of the unfolding post-2015 development process. This is necessary in order to support Member States as representatives of WHO in implementing the post-2015 Sustainable Development Goals (SDGs), in which health is firmly positioned as an overall goal, and in many targets related to sectors other than health.

2015 will see a transition towards a global agenda for sustainable development that is transformative, inclusive, and rights based. Future work will build on the MDGs and will remain Member State-driven, with relevant backstopping from the UN system – including WHO – through technical support teams.

In early 2015, the UN General Assembly will most likely agree on 17 sustainable development goals and 169 targets proposed by the Open Working Group (OWG). The OWG was one of the main outcomes of the United Nations Conference on Sustainable Development (Rio+20), held in 2012.

Health has been firmly positioned in the SDGs. The proposed overarching health goal is: “to ensure healthy lives and promote well-being for all at all ages”. In this context, health is regarded as both an end in and of itself, as well as a means necessary for sustainable development. Accordingly, the proposed health SDG is a measure of overall sustainable development, given that other goals are closely linked with health.

An intergovernmental negotiation process has been tasked to move forward in formulating a political declaration (to be negotiated between March-July 2015), finalizing the SDGs and targets, and formulating a means of implementation and global partnership for sustainable development. In addition, follow-up and final outcome documents will be negotiated.

In parallel, the Statistical Commission, in cooperation with all concerned technical departments, has been tasked with establishing indicators to track the implementation of the goals and targets. Quantification and indicators for the overall health SDG and its sub-goals and targets are indeed necessary to facilitate monitoring of progress and accountability for health in specific and sustainable development in general. WHO leads the inter-agency group on health indicators, with backstopping provided by HQ/HIS. One of the challenges is to come up with a finite number of indicators, given the large number of goals and targets (i.e. the proposed health SDG has as many as 25 sub-targets). The first proposal of the health cluster of the UN Task Team includes 38 indicators; however, the final decision on indicators rests with the statistical commission.

Key messages

Health Goal and indicators

- HWOs are requested to make use of all platforms available to promote collaboration, partnerships and focused advocacy to advance the health agenda and to ensure the inclusion of health indicators into the goals of other sectors. To that end, active involvement with the UN country team (UNCT), and/or UNDAF mechanisms, in addition to other ministries, intersectoral thematic groups, other SDG-related working groups and activities and country consultations, is very important.
• Given that health is an cross-cutting, intersectoral goal, HWOs should undertake outreach to other sectors of the government in addition to health, as well as non-state actors and other relevant stakeholders.

• To ensure effective and efficient implementation of the post-2015 development framework, HWOs need to actively contribute towards consensus building with all partners with regards to how to transit to an integrated, coherent, universal, and inclusive development agenda. This should be done by the identification of areas for human resource development and institutional strengthening with clear roles and responsibilities assigned to all partners. This needs to be coupled with identifying areas of successes and accelerators of progress in achieving the MDGs.

• HWOs should be knowledgeable of the strength and durability of the country’s health system – including health information systems (including surveillance), available resources allocated by the host country (both human and financial), access to relevant knowledge, levels of commitment, and accountability. To that end, the country office should have an updated CCS that includes an analysis of the health system, agreed by the MoH and the country office, to ensure the country office is fit for purpose.

• In order to harmonize and streamline an integrated and collective WHO response to the post-2015 sustainable development agenda, HWOs should share information and provide feedback from the field to other layers of the organization to help inform and complement the process.

Resources

- Proposed Sustainable Development Goals
- TST issues brief: Health and Sustainable Development
  [https://sustainabledevelopment.un.org/content/documents/18300406tstissueshealth.pdf](https://sustainabledevelopment.un.org/content/documents/18300406tstissueshealth.pdf)
- *The road to dignity by 2030: ending poverty, transforming all lives and protecting the planet*: Synthesis report of the Secretary-General on the post-2015 sustainable development agenda
  [http://sustainabledevelopment.un.org/content/documents](http://sustainabledevelopment.un.org/content/documents)
- Ties Boerma: Roadmap paper on indicators and measurement and accountability for health results in the post-2015 era, January 2015
  [http://www.who.int/healthinfo/indicators/hsi_indicators_SDG_TechnicalMeeting_December2015_BackgroundPaper.pdf?ua=1](http://www.who.int/healthinfo/indicators/hsi_indicators_SDG_TechnicalMeeting_December2015_BackgroundPaper.pdf?ua=1)

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Regional and other focal points available from CCU
Policy dialogue: National health policies, strategies and plans towards Universal Health Coverage (UHC)

Background

National health policies, strategies, and plans (NHPSPs) play an essential role in defining a country’s vision, priorities, budgetary decisions and course of action for improving and maintaining the health of its people towards Universal Health Coverage (UHC) where all people obtain the health services they need without financial hardship linked to paying for services. Most countries have been using the development of NHPSPs for decades to give direction and coherence to their efforts to improve health.

The Department of Health Systems Governance and Financing (HGF) provides strategic guidance to countries for the development of appropriate policies and strategies. This includes developing methods, tools and standards to collect, evaluate and introduce relevant information and evidence into policy debate; building capacity to use this evidence and engaging in partnerships with multilateral and bilateral organizations to help develop governance and financing strategies and policies that help countries move closer to UHC. HGF also facilitates effective forms of cooperation between countries and their development partners through its hosting of the secretariat in the International Health Partnership (IHP+) and the Providing for Health, Social Health Protection Network (P4H) 1.

Key messages

- Policies, strategies and plans are not ends in themselves. They are part of the larger process that aims to align country priorities with the real health needs of the population, generate buy-in across government, health and development partners, civil society and the private sector, and make better use of all available resources for health – so that all people in all places have access to quality health care and live longer, healthier lives as a result.

- Without strong policies and leadership, health systems do not spontaneously provide balanced responses to internal and global challenges, nor do they make the most efficient use of their resources. Health systems are subject to powerful forces and influences that often override rational policy making. These forces include disproportionate focus on specialist curative care, fragmentation in a multiplicity of competing programs, projects and institutions, and the pervasive commercialization of health care delivery in poorly regulated systems.

- The development of national health policies, strategies, and plans is a complex and dynamic process. Its precise nature varies from country to country according to the political, historical, and socio-economic context.

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1 The secretariat for IHP+ is jointly housed in the World Bank and WHO, as is the “coordination desk” for P4H. HGF hosts the parts of each that are housed in WHO.
• There is no single blueprint for conducting the policy process. However, key elements include:
  - Population consultation
  - Situation analysis
  - Priority setting
  - Plan formulation
  - Costing and budgeting
  - Implementation
  - Monitoring and evaluation

• It is important for WHO to engage in, and facilitate meaningful sectoral and intersectoral policy dialogue with national stakeholders and global partners around all aspects of NHPSPs within the context of UHC and in line with IHP+ principles for effective development cooperation.

• WHO’s value in the NHPSP process lies in its power to convene, especially, through its relationships with development partners. WHO can play a crucial role in negotiating and brokering different elements of the NHPSP process.

• It is equally important for WHO to offer its technical expertise and facilitate countries’ access to robust guidance, methodology and tools for NHPSP development and costing, assessment, implementation, monitoring, review and evaluation.

Resources

- Information and resources on national health policies, strategies and plans
- Health financing for universal health coverage
- Cost effectiveness and strategic planning
- Health accounts and health expenditure
- Effective development cooperation for health through the International Health Partnership
  [http://www.internationalhealthpartnership.net/en/](http://www.internationalhealthpartnership.net/en/)
- Experiences from 19 countries on making progress towards UHC through a collaborative agreement between WHO and the European Union and Luxembourg to support policy dialogue on NHPSPs
  [http://www.uhcpartnership.net/](http://www.uhcpartnership.net/)
- Country planning cycle database – an open, online resource that provides a country by country overview of the national planning, health programmatic and project cycles, together with information on donor involvement and technical support, for the 195 Member States of WHO
- From whom to whom? Official development assistance for health (fourth edition 2002-2012)
## Contacts

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WHO’s engagement with non-State actors and partnerships

Background

The office of Policy and Strategic Directions (PSD) provides an integrated and enhanced focus to WHO’s policy and strategy development. Housed within the Office of the Director-General, PSD’s primary functions are to support the Director-General in:

- Global policy analysis and strategy development
- Monitoring trends and patterns that effect the delivery of the mandate of WHO
- Partnerships with Member States and engagement with non-state stakeholders
- Coordinating development and implementation of the reform agenda

Key messages

Engagement with non-State actors

- Engagement is a key aspect of WHO’s role in global health governance and non-State actors play a critical role in supporting WHO’s work to fulfil its constitutional mandate. WHO engages with non-State actors in the advancement and protection of public health in order to foster the use of non-State actors’ resources in favour of public health and to encourage non-State actors to improve their own activities to protect and promote public health.

- The objectives of WHO’s engagement with non-State actors are to promote global health as articulated in WHO’s General Programme of Work and to support implementation of the Organization’s policies and recommendations as decided by the governing bodies, as well as the application of WHO’s technical norms and standards.

- As part of WHO reform, the governing bodies have requested the Director-General to develop a Framework of engagement with non-State actors and separate policies on the engagement with different groups of non-State actors

- WHO defines non-State actors as entities that are not part of any State or public institution. They include nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions.

- Engagement with non-State actors at global, regional and country levels calls for a number of measures of caution. Therefore, before engaging with any non-State actor, WHO, in order to preserve its integrity, conducts due diligence. This refers to the steps taken by WHO to find and verify information on a non-State actor and to reach a basic understanding of its profile. WHO will determine through its due diligence if a non-State actor should be considered as nongovernmental organizations, private sector entities, philanthropic foundations or academic institutions.
WHO’s due diligence is internally conducted and combines a review of the information provided by the non-State actor, a thorough search for information and a cross checking of the results about the entity by the unit in charge of conducting due diligence; and an analysis of all the information obtained. This includes a screening of different public and commercial sources of information, including: media; companies’ analyst reports, directories and profiles; and public and governmental sources.

While due diligence refers to the nature of the non-State actor concerned, risk assessment refers to the assessment of a specific proposed engagement with that non-State actor. This involves the assessment of risks associated with an engagement with a non-State actor, in particular conflicts of interest, undue or improper influence; negative impact on WHO’s reputation and credibility; limited benefits for WHO and public health; endorsement of the non-State actor’s name, brand, product or activity; whitewashing of a non-State actor’s image and providing a competitive advantage for a non-State actor.

For the current time, the Principles governing relations between the World Health Organization and nongovernmental organizations (resolution WHA40.25) and the Guidelines on interaction with commercial enterprises to achieve health outcomes (EB 107/20) remain valid. Once adopted, the overarching framework for engagement with non-State actors and the four specific policies will apply to all engagements with non-State actors at all levels of the Organization and will replace both the Principles and the Guidelines.

Partnerships

The Policy on WHO engagement with global health partnerships and hosting arrangements (the “Partnerships Policy”) endorsed in 2010 by the Sixty-third World Health Assembly (in resolution WHA63.10) provides a framework to guide WHO’s assessment of, and decision concerning, potential engagement in different types of health partnerships; it also provides specific parameters to be applied in cases where WHO agrees to host a formal partnership.

The term “partnerships” is being used generically to include various organizational structures, relationships and arrangements within and external to WHO for furthering collaboration in order to achieve better health outcomes. These range from legally incorporated entities with their own governance to simpler collaborations with varied stakeholders. Diverse terms such as “partnership”, “alliance”, “network”, “programme”, “project collaboration”, “joint campaigns,” and “task force” may be used in the title of these partnerships, although this list does not represent a typology.

The term “formal partnerships” refers to those partnerships with or without a separate legal personality but with a governance structure (for example, a board or steering committee) that takes decisions on direction, workplans and budgets. WHO currently serves as the host organization for six formal partnerships which have not been established as legal entities: the Roll Back Malaria Partnership (RBM); the Partnership for Maternal, Newborn and Child Health (PMNCH); the Alliance for Health Policy and System Research (AHPSR); the Global Health Workforce Alliance (GHWA); the International Drug Purchase Facility (UNITAID) and the European Observatory on Health Systems and Policies.
The Partnerships Policy lists ten criteria for assessing WHO’s engagement in future partnerships and guiding its relationship with existing ones. These are as follows: (a) the partnership demonstrates a clear added value for public health; (b) the partnership has a clear goal that concerns a priority area of work for WHO; (c) partnerships are guided by the technical norms and standards established by WHO; (d) the partnership supports national development objectives; (e) the partnership ensures appropriate and adequate participation of stakeholders; (f) the roles of partners are clear; (g) transaction costs related to a partnership must be evaluated, along with the potential benefits and risks; (h) pursuit of the public-health goal takes precedence over the special interests of participants; (i) the structure of the partnership corresponds to the proposed functions; (j) the partnership has an independent external evaluation and/or self-monitoring mechanism.

In hosting a partnership, WHO lends its administrative, fiduciary and legal framework to the partnership secretariat. In this regard, derive their legal personality from WHO and are subject to the Organization’s Rules and Regulations. They have a formal governance structure, separate from that of the WHO governing bodies, in which decisions are taken on direction, work plans and budgets; and their programmatic accountability frameworks are also independent from those of the Organization. WHO-hosted partnerships have not been established by WHO governing bodies.

WHO-hosted partnerships are to be distinguished from United Nations Joint Inter-Agency programmes (such as UNAIDS), inter-organizational facilities (for instance United National International Computing Centre), secretariats hosted in WHO pursuant to an international convention such as the WHO Framework Convention on Tobacco Control (WHO FCTC) and WHO cosponsored programmes (the Special Programme on Research and Training in Tropical Diseases (TDR); the Special Programme of Research, Development Research and Training in Human Reproduction (HRP); the African Programme for Onchocerciasis Control (APOC), the Codex Alimentarius Commission and the Global Polio Eradication Initiative (GPEI).

WHO-hosted partnerships also differ from informal WHO networks and alliances that have been established by the Organization to assist it in implementing its programmatic activities. WHO networks and alliances have no formal governance structure and are predominantly led and managed by WHO.

WHO reports periodically to the Executive Board on its implementation, outlining the various actions it had taken in relation to the different kinds of collaboration covered by the Partnership Policy and their implications for the Organization. Moreover, the Director-General shall submit to the Executive Board any proposals for WHO to host formal partnerships for its review and decision.
Resources

WHO’s engagement with non-State actors


Partnerships

- Guidelines on working with the private sector to achieve health outcomes, Report by the Secretariat, EB107/20
  http://apps.who.int/iris/bitstream/10665/78660/1/ee20.pdf

- Partnerships, Report by the Secretariat, A 63/44

- Resolution WHA 63.10

- Partnerships, Agenda item 18.1, WHA63.10

- Decision WHA65, A65/DIV/3 (pages 5, 6 and 7, paragraph 9)

- WHO’s arrangements for hosting health partnerships and proposals for harmonizing WHO’s work with hosted partnerships, Report by the Secretariat, EB132/5 Add.1

- WHO hosted partnerships, EB132/INF./2.

- WHO reform: hosted partnerships, EB132(10), EB132/DIV./3

- Hosted health partnerships, Report by the Secretariat, EB134/42

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Resource mobilization

Background

“The survey shows that contributors are concerned that WHO’s resource mobilization is fragmented and lacks strategic direction and coordination. Seven out of nine contributors that we interviewed informed us that they look forward to WHO improving its resource mobilization (RM) approach and developing its RM strategy. Contributors want to be approached in a coordinated manner.”

- 2013 Financing Dialogue final evaluation report

WHO is making changes to ensure a more coordinated approach to resource mobilization.

The Coordinated Resource Mobilization unit (CRM) was set up within the Director-General’s Office in 2014, to strengthen coordinated resource mobilization at WHO.

A Global Resource Mobilization Coordination Team (GRMCT) has also been established, bringing together WHO staff from Headquarters, Regional and Country Offices to foster strategic, consistent and coordinated resource mobilization in support of WHO’s Programme Budget.

Key messages

Guiding principles

WHO’s financing is underpinned by four guiding principles, adopted during the 2013 Financing Dialogue:

- **Alignment and flexibility**: funds will be mobilized in alignment with the Member-State approved Programme Budget. Contributor commitments to increase the flexibility of funding will further facilitate an even distribution of funds across programme areas.

- **Predictability**: Member States and other funders strive to make at least 70% of required funding available at the start of a biennium. In addition, the Organization will promote a longer-term view of organizational financing, including by linking the Programme Budget to the six-year General Programme of Work.

- **Transparency**: WHO makes contributor funding information public through its Programme Budget web portal, facilitating a shared understanding of available and projected income by category, programme, major office and budget centre, providing critical inputs to well-informed decisions about voluntary contributions.

- **Reducing vulnerability**: Member States and other funders committed to address the Organization’s reliance on just 20 contributors (11 of which are non-Member State funders) for 80% of all voluntary contributions. This will involve both broadening and deepening the existing contributor base, with an initial focus on Member States.

Approach to resource mobilization

WHO mobilizes resources for the implementation of activities as determined by the World Health Assembly and laid out in the Programme Budget. Voluntary contributions may be accepted “provided that the
Director-General has determined that such contributions can be utilized and that any conditions which may be attached to them are consistent with the objectives and policies of the Organization”.

WHO’s approach to the mobilization of voluntary contributions is, broadly speaking, two-pronged, and involves:

1. Maintaining and deepening support from existing contributors and,
2. Broadening the contributor base.

**Maintaining and deepening support from existing contributors**

WHO relies on 20 contributors (just nine of them Member States) for 80% of its voluntary contributions. Our first priority is to optimize the funding relationship focusing on these top 20, and on the areas of alignment between contributors’ priorities (pan-government in the case of Member States) and WHO.

WHO is committed to improving its stewardship of contributors, including through better evaluation of impact, better reporting on results, and improved visibility to help contributors justify their investments in WHO to their key stakeholders. Biannual financing dialogues and regular bilateral consultations will complement stepped-up day-to-day engagement with contributors.

**Broadening the contributor base**

Interviews carried out as part of a 2014 study on broadening WHO’s contributor base repeatedly stressed that Member States should be the primary funders of WHO. Increasing Member States’ voluntary contributions or supplements to assessed contributions on a voluntary basis is an obvious priority. At the same time, opportunities to mobilize new resources from philanthropic foundations, multilateral institutions and global health initiatives will be pursued.

**Things to consider**

Engagement is a key aspect of WHO’s role in global health governance, and non-State actors play a critical role in supporting WHO’s work.

However, care must be exercised before accepting contributions from non-State actors, to ensure there is no conflict of interest. Details of any potential new donor **must** be shared with Headquarters for review **before** any agreement is signed. The Department of Policy and Strategic Directions (DGO/PSD) will conduct a due diligence review and, if necessary, will consult with the Department of Compliance, Risk Management and Ethics (DGO/CRE) and with Legal (LEG) before approval is granted. Details of these revised procedures and workflows will be communicated in the course of 2015.

Certain types of contributors are prohibited from funding WHO: WHO does not engage with the tobacco and arms industries.

Caution should be exercised when engaging with other industries. Any private sector engagement involving funding needs a prior due diligence and risk assessment by HQ/DGO/PSD.

A comprehensive framework for engagement with non-State actors is being developed and should be presented for approval by the World Health Assembly in 2015.
Resources

- Programme Budget web portal
  
  A Programme Budget web portal, updated every quarter, has been established to provide Member States and other partners with information on budget requirements, availability and distribution of funding, funding gaps, financial implementation and programme performance. 
  
  https://extranet.who.int/programmebudget/

- Funding page on www.who.int

- The funding page on the public WHO website contains basic information on how the Organization is funded and who provides this funding. 
  
  http://who.int/about/funding/en/

- CRM page on the intranet

- Contains internal information, including standard agreements, procedures and profiles on our top 33 Member State contributors. 
  
  http://intranet.who.int/homes/crm/

- Investing in the World’s Health Organization

- This document aims to provide Member States and other partners with an easy-to-read overview of the Programme Budget. 
  
  http://who.int/entity/mediacentre/events/2013/financing-brochure-en.pdf?ua=1

- eManual

- See section IV.1 Mobilizing Resources from donors

  http://emanual.who.int/p04/s01/Pages/default.aspx

Contacts

- For the contact details of the Global Resource Mobilization Coordination Team (including focal points for each of the Regions, Programme Budget categories and for our top contributors) please see the CRM page on the intranet. Alternatively, questions can be sent to financing@who.int.
Collaboration with the United Nations system

Background

"WHO is committed to a more coherent approach to the United Nations work at country level, to aligning of support to national priorities, to promoting the place of health in United Nations Development Assistance Frameworks and One UN plans, and to coordinating the health cluster in emergencies."

> 12th General Programme of Work, paragraph 121

"Maximizing convergence with the UN system reform to deliver effectively and efficiently on the UN mandate", is one of the outputs of the reform implementation plan, contributing to strengthening effective engagement with WHO’s partners in promoting greater coherence in global health.

The Department of Country Cooperation and Collaboration with the UN System (CCU) leads collaboration with the United Nations system across three levels of the Organizations, especially within main UN coordinating bodies; participates in the policy debates on UN operational activities for development; provides inputs on health issues for the SG reports; and maintains bilateral relations with UN funds, programmes and specialized agencies. CCU supports country offices in working as part of a United Nations Country Team (UNCT) both directly and through a network of regional focal points.

WHO Office at the United Nations (WUN) represents the interests of WHO at the UN and functions as the Organization’s main interlocutor with the United Nations system in New York. WUN facilitates DG and high-level WHO participation in meetings of the UN General Assembly, ECOSOC, Security Council, Inter agency briefings, events and interaction with the UN press corps.

Key messages

Overview

- Working with the UN provides an opportunity to promote a multi-sectoral approach in responding to health challenges, by addressing key economic, social and environmental determinants of health; as well as to access additional funding through joint resource mobilization and MDTFs.

- The Country Cooperation Strategy (CCS), closely aligned with national health policies, strategies and plans, is the main instrument for harmonizing WHO’s cooperation in a country with that of other UN agencies and development partners. Its key components should be reflected in the United Nations Development Assistance Framework (UNDAF)/One Programme, and not replaced by it.

- UNDAF will be used as a main tool to identify the UN system’s support to Member States in addressing the challenges of the post-2015 development agenda.

- As part of the cost-sharing agreement, WHO contributed US$ 5.2 million for the 2014/15 biennium to a centralized funding of the Resident Coordinator system. This will fund 10 essential coordinating functions of the RC at country level, as well as support from global and regional levels. This agreement replaces requests for funds at country level. However, if a country office wants to joint other joint activities, undertaken by the UNCT, aligned with WHO priorities, CCS and biennial programme of work (BPW), the country office can contribute resources and staff time.
• WHO works with UN Member States and other stakeholders to ensure that health features prominently in the post-2015 sustainable development agenda (to succeed the MDGs), expected to be adopted by the UN Member States at a Summit in New York in September 2015 (see chapter 1.1).

• WHO works closely with UNMEER, the first ever UN mission for a public health emergency, established by the Secretary General in September 2014 to bring together the UN agencies, civil society and private sector to address the social economic and security concerns due to the Ebola outbreak. In New York, WUN plays a lead role informing UN partners and member states on WHO’s work and making sure that our response efforts are reflected in the political discussions at the UN.

**Delivering as One (DaO)**

• By November 2014, 43 countries have voluntarily adopted the DaO approach. It is a clear trend in near future.

• DaO approach is based on five pillars: One Programme; Common Budgetary Framework and One Fund; One Leader; Operating as One; and Communicating as One.

• The UN Development Group (UNDG) adopted the “Standard Operating Procedures (SOPs) for Countries Wishing to Adopt the DaO Approach with an integrated support package” in July 2014.

• WHO developed a “WHO guidance on the Standard Operating Procedures (SOPs) for Delivering as One (DaO) countries”, which provides practical guidance to regional and country offices in the implementation of the SOPs.

• Harmonization of business practices should be based on a cost-benefit analysis. Note that until business practices are fully harmonized at the global level, the agency specific rules and procedures will continue to apply.

**Resources**

- WHO’s work with the United Nations website and WUN intranet
  [http://intranet.who.int/homes/wun/news/](http://intranet.who.int/homes/wun/news/)


- Standard Operating Procedures for countries wishing to adopt the “DaO approach” with an integrated package for implementing by UNCTs. August, 2014.

- WHO Guidance on the Standard Operating Procedures (SOPs) for DaO countries

- UNDAF Guidance and support package
  [https://undg.org/home/guidance-policies/common-country-programmingundaf/](https://undg.org/home/guidance-policies/common-country-programmingundaf/)
Resident Coordinators annual reports
https://undg.org/home/resident-coordinators/synthesis-of-resident-coordinator-annual-reports/
Open Working Group proposal for Sustainable Development Goals

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The WHO Country Cooperation Strategy

Background

The Country Cooperation Strategy (CCS) is WHO’s key instrument to guide its work with and in countries, territories and areas. It is a medium-term vision for WHO’s technical cooperation with a given Member State, in support of its National Health Policy, Strategy or Plan (NHPSP).

- It is the strategic basis for the elaboration of the Biennial Country Programme Budget and Work Plan.
- It is the main instrument for harmonizing WHO’s cooperation in countries with that of other UN system organizations and development partners.
- The timeframe is flexible to align with national planning cycles. It is generally 4–6 years.

Key messages

The CCS Corporate Framework 2014 takes into consideration the WHO Country Focus Strategy anchored in WHO reform. It reflects the expected linkages of the CCS with the six Leadership Priorities (LP) and the new results chain hierarchy of the 12th GPW.

The CCS development/renewal/evaluation process is led by the HWO and is undertaken in extensive consultation and strategic dialogues with all relevant stakeholders at the country level and across the three levels of the Organization.

The formulation of the CCS Strategic Agenda is the core of the CCS process. The CCS Strategic Agenda is defined through a prioritization exercise with the government – at the highest level possible – as well as other partners, including other UN agencies. The prioritization takes into account the results of a very strong health situation analysis, the national health priorities, the six 12th GPW Leadership Priorities, the contributions of other UN agencies and development partners to the NHPSP, as well as WHO’s comparative advantage.

The Strategic Agenda consists of a set of three to five strategic priorities for WHO cooperation in and with the country that are jointly agreed to with national authorities, and in support the NHPSP. Under each Strategic Priority are a maximum of one to three CCS outcomes, where WHO will concentrate its work. These CCS outcomes which are linked to GWP outcomes, will inform the country programme budget and work plan.

The finalized CCS is a strategic management tool that should be used by the HWO and the WHO country team to:

- Review and adjust country presence and cooperation in support of the NHPSP;
- Formulate the Biennial Country Programme Budget;
- Shape the health dimension of the CCA/UNDAF and other partnership platforms in countries;
- Negotiate support inside and outside WHO;
- Create dialogue for cooperation with partners;
Advocate and mobilize resources;

Communicate on WHO’s involvement in the country.

The scope of the CCS varies according to the country’s context. It needs to be contingent on the member state’s specificities and circumstances (i.e. fragile situation, disaster prone, high income, etc.).

Before or immediately after taking office, the newly appointed HWO needs to inquire about the status of the CCS. Is the CCS current or does it need to be renewed? Is the process of renewal already underway?

If a CCS exists, read it carefully and with your team analyse if:

1. The CCS is aligned to the NHPSP.
2. The CCS informs the biennial country program budget and work plan(s). Assess the adequacy of the linkage between these documents.
3. The work plan is being used to implement the CCS strategic agenda.
4. If the work plan(s) is not fully aligned to the CCS (and/or the NHPSP), inquire why this is the case.
5. Every member of the country team is well-briefed on the CCS and encouraged to use it for integrated programme planning.
6. The CCS is harmonized with the UNDAF or DaO, if in place.

If a CCS does not exist or needs renewal or evaluation, consult with the regional country support entity on how to initiate the process; simultaneously, initiate dialogue with the national authorities to determine the feasibility of creating or renewing the CCS.

Take advantage of other on-going national processes at country level, where appropriate, to initiate the CCS process in order to reduce transaction costs and achieve better harmonization with national cycles.

Resources

- WHO Country Cooperation Strategies and briefs
- The Guide for the formulation of the WHO Country Cooperation Strategy

Contacts

Country Support Units (CSUs):

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Part II
Technical cooperation, policy advice and dialogue
Health systems strengthening (HSS) for Universal Health Coverage (UHC)

**Background**

Over a billion people are not able to use the health services that they need, and 100 million are pushed into poverty each year as a consequence of paying for the services they receive\(^2\). Universal Health Coverage (UHC) is a response to this; it is a condition in which all people are able to use the services they need (including prevention, promotion, treatment, rehabilitation and palliation), that those services are of good quality, and that the use of these services does not cause substantial financial hardship. Put another way, UHC means providing the assurance that the health services people need are available, affordable and of good quality. It is grounded in a human rights approach, for example the Universal Declaration of Human Rights and the WHO Constitution, as well as many national constitutions.

The goals embedded in UHC — equity in service use relative to need, quality, and financial protection — are not “owned” by any single part of the health system or WHO department; progress requires coherent action across the system and Organization.

- UHC is about goals and objectives
- HSS is about policy instruments and reforms in the “building blocks” of service delivery, human resources for health, medicines and technologies, information, health financing, and leadership/governance.
- Countries may use the expression “implementing UHC reforms”, but in practical terms, UHC is not something than can be “implemented”. Instead, the idea is to strengthen health systems in order to make progress towards UHC.

**Key messages**

- UHC has been described as an “aspirational goal”, but it is more than that. The expression “moving towards UHC” means making progress on any/all of the goals of equity in service use, quality, and financial protection. As such, it is relevant to all countries, as all have room for improvement.
- Part of the practical aspect of the “UHC goals” is that they can be measured.
- HSS does not simply mean “investment” in any of the six building blocks. While support to the system is often needed, “strengthening” implies changing how the system functions in order to make sustained progress towards UHC.
- Moving towards UHC requires aligned actions across the system, oriented to progress on these goals. Isolated reforms, such as only working on health financing or only on HRH, are unlikely to yield much progress.
- UHC, meaning that all people are able to access high quality and safe health services that meet

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their needs and expectations, will not be achieved without improvements in service delivery, so that. Moves towards UHC without adopting the principles of people-centred and integrated care are likely to result in fragmented, inefficient and unsustainable health services. Services must aim to provide a continuum of care that covers all of the population needs, in an integrated way, and across the whole of their life course.

- There is no standard package of HSS actions to progress towards UHC. The context (e.g. income level, fiscal capacity, political system, administrative decentralization, etc.) of each varies, as does its “starting point” of the existing health system. Countries share the goal of UHC, but the operationalization of that goal is context-specific.

- To make progress, it is essential to diagnose the ways that the system is under-performing relative to the goals embedded in UHC, but moving beyond slogans into the specific manifestations of the problems in a particular country. Moving towards UHC is not about implementing any particular “model” of reform, but rather about solving problems, i.e. addressing the barriers to progress. This requires strong analytic capacity in country and the means to link evidence to decision-making.

- There are, of course, factors outside the health system that influence and constrain progress towards UHC. These social determinants are important, and the challenge for health system leaders is to identify those that can be either influenced by policy (and to advocate for these) or the ways that the health system needs to adapt to compensate.

WHO’s role

- Globally, WHO has been a strong advocate for UHC and has built strategic alliances with other key international actors, most prominently the World Bank. UHC also figures prominently in the post-2015 Sustainable Development Goal discussions.

- WHO has produced a joint UHC monitoring framework with the World Bank. This framework can be usefully adapted and tailored to specific country needs for tracking progress.

- At both global and country levels, WHO must demonstrate a clear commitment to the goal of UHC while maintaining neutrality on the inherent benefits of any particular set of reforms. At country level, we need to push dialog beyond general statements of UHC and towards specific ways that problems of equity in service use, quality and financial protection manifest themselves. Related to this, it is important to orient the national health policy planning and implementation process towards addressing the likely causes of these problems, drawing on both national and international evidence as appropriate.

- Given some confusion around both HSS and UHC, particularly in country-level debates on health reform options, WHO has a key normative role to play in brokering these debates. Being effective in this role requires ensuring conceptual clarity. The following illustrative table may be of some help in thinking about how we can play this role:
UHC is about goals (what we want to achieve) | HSS is about instruments (what we do, for example...)
---|---
Equity in service use relative to need, for equity in health goal | Better mix, distribution and capability of HRH
Quality improvement, for improving health | Targeted incentives to promote use of priority services
Universal financial protection | Investment in effective public health services
(and intermediate objectives like equity and efficiency in resource use) | Reorganization of service delivery with an integrated people-centered approach

WHO also provides technical assistance and capacity building in different areas of HSS and the monitoring of progress towards UHC. We have a key role to play at country level as a neutral, objective advisor and supporter of policy development.

**Resources**

- World Health Report 2010
- World Health Report 2013
  [http://apps.who.int/iris/bitstream/10665/85761/2/9789240690837_eng.pdf](http://apps.who.int/iris/bitstream/10665/85761/2/9789240690837_eng.pdf)
- PLOS Medicine Collection on Monitoring UHC:
- HQ UHC web page (includes links with key documents, DG speeches, videos, and other useful information)

**Contacts**

- HQ: ADG for HIS – Marie-Paule Kieny
- Regions: The Director of Health Systems (or equivalent) in each RO
Health statistics and information systems

Background

The production and dissemination of information to monitor health trends and determinants for evidence informed health policy at the country, regional and global levels are core WHO activities mandated by the Member States in the Constitution. All countries need to be able to generate timely and high quality data and statistics on mortality by age, sex and cause of death; disease incidence and prevalence; coverage of interventions, including safety, effectiveness and responsiveness of services; prevalence of risk factors; financial protection from health expenditure; and data on health system inputs and outputs to manage and plan services. These are required as the basis for the regular assessment of national progress relating to internationally agreed health goals and targets (the MDGs and the post-2015 Sustainable Development Goals) as well as to new and emerging priorities such as non-communicable diseases, mental disorders, injuries and universal health coverage, driven by population ageing and epidemiological changes.

Country monitoring is also the basis for regional and global health monitoring and accountability. Currently over 90 targets and over 100 indicators have been endorsed by Member States at the World Health Assembly and other governing bodies. There are also many other recommended indicators to cover the full array of health priorities that are synthesized in a 2015 Global Reference Set of 100 Core Health Indicators.

Strong country health information systems are at the core of tracking these trends. As described in the IHP+ Monitoring and Evaluation (M&E) framework, a strong country information and accountability platform is characterized by a comprehensive national M&E plan; institutional capacity among state and non-state actors; an M&E framework that specifies core indicators; data sources, analysis and use; and inclusive transparent country mechanisms for review and action. Country health information systems draw upon multiple data sources, including civil registration and vital statistics systems, population-based surveys, health facility and administrative information systems, are led by country institutions and use international standards. Country generated health information should also have a clear audit trail.

WHO and global health statistics

WHO figures carry great weight in national and international resource allocation, policy-making and programming, because of WHO’s reputation as being unbiased (impartial and fair), global (having a worldwide remit and responsibility) and technically competent (drawing on leading research and policy institutions and individuals). WHO works closely with countries, partners and global experts to produce health statistics of the greatest possible accuracy. Periodic updates of global health estimates usually involve statistical modelling to overcome major gaps in country data availability and quality and to obtain comparable global, regional and country health statistics.

An important feature of WHO’s global health monitoring is its commitment to transparency and consensus. This is achieved in several ways:

- WHO collaborates with other UN agencies to combine technical resources and ensure that a single UN estimate is provided, for instance, for monitoring progress towards the targets for the Millennium Development Goals.
• Technical advisory groups comprised of independent academic experts provide methodological advice to WHO and other collaborating UN agencies on health estimates.

• A country consultation process provides a platform for Member States to understand how estimates are derived, and for WHO to identify additional data sources that can be used to improve the accuracy of estimates. It is a consultation process, not a clearance, meaning that WHO and country best estimates may differ because of differences in data used and methodology.

• WHO and collaborating agencies have set a standard for transparency and reproducibility, as input datasets and statistical code/modelling software are now freely available for several major disease areas (maternal mortality, child causes of death, infant and child mortality, and HIV/AIDS), allowing Member States and other interested parties to understand and replicate those analyses.

The goal is to have all estimates accompanied by tools that can be used by countries to better understand the estimates, alter input data and assumptions as appropriate.

Key messages

WHO has a central role in supporting countries in strengthening the availability, quality accessibility and use of health statistics. Specifically, WHO’s critical functions at country office level include:

• Providing support to Member States for the collection, analysis and reporting of indicators and targets, endorsed by Member States through World Health Assembly declarations and resolutions and other governing bodies in addition to country specific needs.

• Providing technical advice and support for the introduction, expansion and improvement of civil registration systems in the many Member States which still do not have fully functioning systems, with a particular emphasis on death registration with collection of information on age, sex and underlying cause of death. Identifying capacity-strengthening needs, and supporting countries in the use of national information and data for analysing and monitoring the national health and health financing situation and trends, and progress towards universal health coverage, as part of accountability mechanisms such as health sector reviews.

• Providing strategic and technical support to the development of the country monitoring and evaluation plan as part of the national health sector strategy and plan. This includes support for progressive alignment of programme-specific monitoring and reviews with overall health monitoring, using the same indicators, data collection, and time cycles, thereby simplifying and reducing reporting requirements.

• Promoting the use of international standards and classifications for data and health information, including the implementation of the family of international classifications (including ICD, the global reference list of core health indicators, data quality assessment tools, standards for household surveys and facility information systems, health workers among others).

• Working with development partners to advocate for the strengthening of a single country-led platform for information and accountability, as described in the IHP+ framework for monitoring national health strategies, in order to facilitate improved coordination of investments in data collection and quality verification and analytical capacity that strengthen the national monitoring systems.
• In coordination with the regional office and headquarters, consolidating and disseminating national information on the health situation and trends for inclusion in national, regional and global health observatories.

• Building country office capacity to coordinate health information activities across the different technical programme areas and to facilitate the consultation process between Ministry of Health focal points on global, regional and country estimates.

Resources

› Towards a monitoring framework with targets and indicators for the health goals of the post-2015 Sustainable Development Goals  
http://www.who.int/healthinfo/indicators/hsi_indicators_sdg_targetindicators_draft.pdf

› 2015 Global Reference List of 100 Core Health indicators  
http://www.who.int/healthinfo/indicators/en/

› Global Health Agency leaders statement on indicators and reporting requirements  
http://www.who.int/healthinfo/indicators/en/

http://www.who.int/healthinfo/universal_health_coverage/en/

› Monitoring, evaluation and review of national health strategies: a country-led platform for information and accountability. World Health Organization. International Health Partnership  
http://www.who.int/healthinfo/country_monitoring_evaluation/documentation/en/

› Civil Registration and Vital Statistics (CRVS)  
http://www.who.int/healthinfo/civil_registration/en/

› Data quality assessment tools  
http://www.who.int/healthinfo/tools_data_analysis/en/

› Health data and statistics  
http://www.who.int/healthinfo/statistics/en/

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Health financing for universal health coverage

Background

Health financing is one of the health system “building blocks”, and is comprised of:

- **revenue collection** – sources of funds and contribution methods, such as taxes (including compulsory insurance contributions), out-of-pocket payment at the point of use, voluntary prepayment (often private or community based health insurance), and external grants and loans.

- **pooling of funds** – accumulation of prepaid funds on behalf of some or all of the population.

- **purchasing of services** – allocation of revenues and resources to health service providers.

- **benefit design and rationing** – policies with regard to the health service entitlements and obligations of the population, sometimes referred to as the “benefits package”, including what services are covered from prepaid funds, for which populations, and at what out-of-pocket cost at the time of use (“rationing” most commonly takes the form of patient cost-sharing, such as co-payments or user fees, but may also include the exclusion of certain services from coverage or the imposition of waiting lists).

- **governance arrangements for the financing system** – this includes things aimed at aligning such as the regulation of insurers, providing information to the population on their entitlements, or establishing the reporting requirements for health service purchasing agencies such as social health insurance funds.

Progress towards UHC requires a concerted effort at strengthening the health system, and health financing reforms are a critical part of that process. Broadly, as outlined in the World Health Report (WHR) 2010 (“Health System Financing: the Path to Universal Coverage”), there are three areas of focus for moving countries towards UHC through financing reforms:

- Raise “more money for health”;

- Get “strength in numbers”, i.e. increase the share of prepaid, pooled funding in the system while reducing barriers to redistribution of those funds:

- Get “more health for the money”, i.e. improve efficiency and equity in the use of health system resources.

Key messages

UHC and the potential for progress through health financing reforms are relevant to all countries, regardless of their income. While UHC broadly sets the direction for reform, country context differs in terms of both its existing health system and wider contextual factors (e.g. income, poverty, capacity to mobilize tax revenues, extent of decentralization in the public sector). As a result, there is “no one size fits all” set of financing reforms to apply to every country. However, country experiences do provide valuable lessons that can serve as signposts to guide progress, and also as warnings against pitfalls to avoid.
• **Countries need to move towards predominant reliance on public/government funding sources for their health systems.** Experience shows clearly that where governments are able to spend more, systems depend less on out-of-pocket spending (OOPS). OOPS is the most regressive way of financing the health system, placing financial burden on the sick and the poor. High dependence on OOPS (e.g. more than 20-30% of total health spending) is also associated with increased probability of financial protection problems for the population.

• Public funding sources include revenues raised from government-owned natural resources, various forms of taxation (e.g. income tax, value-added tax, excise taxes, etc.) and compulsory contributions for health insurance (often called “social health insurance” contributions or “payroll taxes”). Private funding sources include OOPS as well as voluntary health insurance (VHI). VHI can be organized in different ways, including voluntary private commercial health insurance, voluntary community-based health insurance (CBHI), or even voluntary participation for part of the population in a publicly managed health insurance program.

• **No country has made much progress towards UHC by relying mainly on VHI.** This is due to shortcomings of voluntary markets for health insurance rather than whether the VHI fund is owned by a private entity or a community. Countries that anticipate high levels of participation in voluntary schemes are not being realistic.

• For all of these reasons, and also because they have greater capacity to mobilize tax revenues, richer countries tend to rely predominantly on public funding for their health systems. For low and middle income countries (LMICs) this can be a challenge because LMICs tend to have less fiscal capacity than richer countries. Measures to increase “fiscal space for health” include increasing the priority for health in the distribution of public spending (e.g. African heads of state agreed to devote 15% of public spending to health), to mobilize more tax revenues (e.g. by improving their tax administrative systems, by raising existing tax rates or by introducing new types of taxes), and to obtain more external sources where relevant (e.g. donor funding). WHO’s Global Health Expenditure Database provides an excellent source of both national and comparative data on health spending patterns from various sources, and national health account (NHA) studies provide detailed data on the sources and uses of funds within a health system.

• **Health financing reforms should also seek to reduce fragmentation in pooling arrangements to expand the potential for redistribution from prepaid funds.** Fragmentation means the existence of barriers to the potential for systems to cross-subsidize in favour of those with the greatest health needs. Such barriers can take different forms, but common ones are the existence of different insurance schemes for different population groups, the existence of a social health insurance fund that serves mainly the formal sector population while the rest of the population relies on relatively poorly funded public services, and decentralized government health budgetary arrangements in which public funds are managed on behalf of geographic areas serving small population groups. As a result, the financing reform agenda in many countries includes options to integrate different pools or to enable a degree of cross-subsidization between them.

Another key health financing reform theme is to **move towards strategic purchasing of health services.** This means linking the payment of providers to information on some aspects of their performance, the health needs of the populations that they serve, or a combination. This requires both the capacity to analyse relevant data and allocate resources accordingly, as well as relatively flexible administrative ar-
rangements that allow public funds to be distributed in ways other than historical line budgets. Because this flexibility is hard to achieve within the core public budget system, many countries have established quasi-public health insurance funds that are still accountable to government but operate under different rules that allow them to use different provider payment methods. Obtaining the potential gains from changed provider incentives often requires parallel changes at provider level, typically to increase managerial autonomy in public providers and ensure clear accountability in the relation with non-state providers.

One form of strategic purchasing that has gained prominence in recent years is **results-based financing** (RBF), which is sometimes referred to as **performance-based funding** (PBF) or **pay-for-performance** (P4P). Whatever the label used, this generally refers to some explicit link between defined benefits and the payment mechanism used for those services (e.g. promoting delivery of child health services by paying health centres for each child served, encouraging immunization or screening by paying a bonus if targets are met or exceeded, etc.). It should be noted that these labels are somewhat misleading and may cause undue optimism about what they can achieve, as they typically involve paying for an activity that is believed to be associated with good outcomes rather than for “performance” or “results” per se. While financial incentives can help, they can at best play only a supportive role in a wider quality improvement or service extension strategy.

**WHO’s role**

- WHO has a long history of involvement in health financing, though this was reinforced and strengthened with the publication of WHR2010 on *Health Systems Financing: the Path to Universal Coverage*.

- WHO aims to promote conceptual clarity on health financing, in particular the disaggregation into revenue contribution/collection, pooling, purchasing, and policies on benefit design and rationing. We reinforce this through our own (global, regional and national) training programs as well as those delivered in collaboration with partners.

- WHO also promotes the use of standard methodologies for cost-effectiveness analysis, the costing of national health plans, and expenditure tracking to support priority setting, strategic planning, and national health accounts, and provides direct support to countries on the implementation of these tools.

- Because health financing always involves other sectors – at least finance ministries and often other ministries as well – WHO works with partner agencies at global and country levels to promote a coherent approach while striving to take advantage of each partners’ natural “entry point” into policy dialog. This includes but is not limited to the Providing for Health Network (P4H).

- At country level, it is important to recognize that health financing reform aimed at promoting progress towards UHC is inevitably political, not least because reform often incorporates some degree of redistribution, as well as the need to set priorities in the face of resource constraints. This gives added importance to WHO’s role as a neutral broker in policy discussions.

- WHO is very active in supporting countries to develop, revise, and analyse their health financing strategies and related implementation plans. The Country Office plays a leading role in this process, strongly supported by the Health Financing Advisors and team at Regional Office, and often engaging colleagues in HQ as well.
Resources

- World Health Report 2010 "Health systems financing: the path to universal coverage"
- http://www.who.int/whr/2010
- HQ UHC web page - includes links with key documents, DG speeches, videos, and other useful information
  - http://www.who.int/universal_health_coverage/en/
- Links to key tools for health financing situation analysis (OASIS) and priority setting (WHO-CHOICE)
- Global Health Expenditure Database
  - http://apps.who.int/nha/database/QuickReports/Index/en
- OneHealth Tool
  - http://www.who.int/bulletin/volumes/90/11/12-113654/en/
- Providing for Health Network website
  - http://p4h-network.net/

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Noncommunicable diseases

Background

Over 16 million people die each year from noncommunicable diseases (NCDs) before the age of 70, of which 82% are in developing countries. It is estimated that up to two thirds of these premature deaths are linked to exposure to four risk factors - tobacco use, unhealthy diet and physical inactivity, and the harmful use of alcohol – and up to half of all such deaths are linked to weak health systems that do not respond effectively and equitably to the needs of people with NCDs – principally cardiovascular diseases, cancers, chronic respiratory diseases and diabetes. Most premature deaths from NCDs can be prevented by governments taking a leading role and responsibility in implementing a package of very cost-effective and affordable multisectoral interventions.

The 2011 UN Political Declaration on NCDs acknowledges that NCDs constitute a major development challenge and includes a roadmap of concrete commitments from Heads of State and Government. The 2014 UN Outcome Document on NCDs includes four time-bound commitments: to consider setting national targets and develop national multisectoral action plans by 2015; and start reducing risk factors and enabling health systems to respond by 2016.

In 2013, the WHA endorsed nine global NCD targets for 2025, organized around the WHO Global NCD Action Plan 2013-2020. The Global Action Plan comprises a set of actions which, when performed collectively by Member States, international partners and WHO, will achieve a global target of a 25% reduction in premature mortality from NCDs by 2025 and achieve the commitments made in the 2011 Political Declaration.

To meet the rapidly increasing demand from developing countries for technical assistance in the area of NCDs, the United Nations Secretary-General established the UN Interagency Task Force on NCDs in 2013. The Task Force is under WHO leadership and coordinates the activities of UN organizations and other intergovernmental organizations to support the commitments made in the 2011 Political Declaration. In 2014, WHO established the WHO Global Coordination Mechanism on NCDs to facilitate and enhance coordination of activities, multi-stakeholder engagement and action across sectors to contribute to the implementation of the WHO Global NCD Action Plan 2013-2020.

The proposed sustainable development goals includes a target to “by 2030, reduce by one-third premature mortality from NCDs through prevention and treatment and promote health and well-being”.

Key messages

- NCDs remain hidden, misunderstood and underreported in most developing countries and addressing NCDs is not considered relevant to addressing development. **HWOs should call on governments to realize their commitment made in the 2014 Outcome Document to raise awareness about the national public health burden causes by NCDs and the relationship between NCDs, poverty and socio-economic development, in close collaboration with the UN Country Team (UNCT) and other partners.**

- Even if addressing NCDs is considered relevant to development, there is often a misperception that no health gains for NCDs can be achieved within the short- or medium-term, or within the term that the government will be in office. **HWOs should call on governments to realize their**

- Even if efforts are undertaken to address NCDs, these are often not sufficiently focused and progress made may not be regularly assessed. **HWOs should call on governments to realize their commitments made in the 2014 Outcome Document to consider setting national targets for 2025 and process indicators based on national situations, taking into account the nine global targets for NCDs and the 25 outcome indicators included in the WHO Global Monitoring Framework on NCDs, to focus efforts and to assess progress made towards.**

- Monitoring NCDs and their determinants provides the foundation for advocacy, policy development and national action. Monitoring is not limited to tracking data on the magnitude of and trends in NCDs, it also includes evaluating the effectiveness and impact of interventions and assessing progress made. **HWOs should call on governments to realize their commitment made in the 2014 Outcome Document to develop or strengthen surveillance systems to track NCDs and their risk factors, and contribute information on trends in NCDs to WHO according to agreed timelines at the WHA, coordinating country reporting with global analyses.**

- Premature deaths from NCDs are largely preventable by means of effective interventions that tackle shared risk factors, namely tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol. **HWOs should call on governments to realize their commitment made in the 2011 Political Declaration that prevention must be the cornerstone of the national response to NCDs and encourage a focus to reduce these risk factors by 2016 through the implementation of interventions and policy options to create health-promoting environments, building on Appendix 3 of the WHO Global NCD Action Plan 2013-2020.**

- The provision of health care for NCDs is often not dealt with in the context of overall health strengthening through people-centred primary care and universal health coverage. **HWOs should call on governments to realize their commitment made in the 2014 Outcome Document to strengthen health systems by 2016 through people-centred primary health care and universal health coverage throughout the life cycle, building on guidance set out in Appendix 3 to the WHO Global NCD Action Plan 2013-2030.**

- The underlying determinants of NCDs and their shared risk factors mean that multisectoral, whole-of-government and whole-of-society responses are required to prevent and control NCDs. **HWOs should call on governments to realize their commitment made in the 2014 Outcome Document to consider establishing a national multisectoral mechanism (such as a high-level commission, agency or task force) for engagement, policy coherence and mutual accountability of different spheres of policymaking that have a bearing on NCDs.**
WHO is helping governments develop and share “best buy” solutions to address NCDs, based on global perspectives and local insights. WHO is also helping countries understand the dimensions that influence NCDs outside the health sector, including public policies in agriculture, education, food production, trade, taxation and urban development. WHO focuses on providing technical assistance to countries in four areas:

- Governance: setting national targets, establishing national multisectoral mechanisms, developing national strategies
- Risk factors: developing national plans to reduce tobacco use, harmful use of alcohol, physical inactivity and unhealthy diet
- Management of NCDs: developing national plans to enable health systems to respond to the health-care needs of people with cardiovascular diseases, cancers, diabetes, and chronic lung diseases
- Surveillance: STEPs surveys, implementing the WHO Global NCD Monitoring Framework.

HWOs should offer these technical assistance services to the government with a view to accelerate national efforts to address NCDs.

The WHO Framework Convention on Tobacco Control (WHO FCTC) is the first and only treaty negotiated under the auspices of WHO. It asserts the importance of demand reduction strategies as well as supply issues. It also asserts the obligation to protect public health policies from the interests of the tobacco industry. HWOs should encourage member states that are parties to the WHO FCTC to implement it fully and quickly. HWOs should encourage member states that are not Parties to the WHO FCTC to become one. HWOs should implement the Guidelines for Responding to Requests Made By the Tobacco Industry to Meet with WHO approved for Global WHO Circulation on 21 August 2007

The importance of mobilizing UNCTs in responding to NCDs has been highlighted in two joint letters UNCTs from the Administrator of the United Nations Development Programme (UNDP) and the Director-General of WHO to UNCTS. The first letter, in 2012, proposed UNCTs integrate NCDs into UNDAF design processes and implementation. A second joint letter, in 2014, reiterated the importance of mainstreaming NCDs into UNDAF rollout processes and encouraged UNCTs to scale up their capacities to support governments in implementing these priority actions. An analysis done in 2013, shows that NCDs are insufficiently integrated into UNDAFs. HWOs should establish a resident UN Thematic Group on NCDs (or equivalent) that focusses on NCDs (or, in the case of an existing UN Thematic Group on Health, includes NCDs in its ToRs). HWOs should ensure that NCDs are included in UNDAFs.

A whole of society response means engaging with NGOs, academia as well as selected private entities. Such engagement by governments and UNCTs with non-State actors at country levels also calls for a number of measures of caution. The risks include influence by a non-State actor to obtain a competitive advantage or undue endorsement, limiting the benefits to public health, whitewashing a non-State actor’s image through its association with public health objectives, or affect the independence and objectivity of the work of the government and/or UN Country Team. In order to be able to strengthen its engagement with non-State actors for the benefit of health and in the interest of all actors, HWOs should support governments and UNCTs strengthen their management of the associated potential risks.
Resources

The WHO NCD web page ([www.who.int/nmh](http://www.who.int/nmh)) provides a wealth of information of NCDs. The site includes relevant publications ([http://www.who.int/nmh/publications](http://www.who.int/nmh/publications)). They include:

- WHO NCD country profiles 2014
  [http://www.who.int/nmh/countries](http://www.who.int/nmh/countries)
- Second WHO Global status report on NCDs 2014
- A section of WHO tools to prevent and control NCDs is available and sets out tools by the 9 voluntary global targets and 25 indicators as well as each of the 6 objectives of the WHO NCD Global Action Plan, 2013-2022, each of the 4 major NCDs and 4 main risk factors
  [www.who.int/nmh/ncd-tools](http://www.who.int/nmh/ncd-tools)
- 2014 UN Outcome Document on NCDs
  [http://www.who.int/nmh/events/2014/a-res-68-300.pdf?ua=1](http://www.who.int/nmh/events/2014/a-res-68-300.pdf?ua=1)
- 2011 UN Political Declaration on NCDs
  [http://www.who.int/nmh/events/un_ncd_summit2011/political_declaration_en.pdf?ua=1](http://www.who.int/nmh/events/un_ncd_summit2011/political_declaration_en.pdf?ua=1)
  [http://apps.who.int/iris/bitstream/10665/94384/1/9789241506236_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/94384/1/9789241506236_eng.pdf?ua=1)
- Guidance note on the integration of NCDs into the United Nations development assistance framework (in press, web link available shortly)
- WHO Framework Convention on Tobacco Control
- Global Status Report on Alcohol and Health 2014 with country profiles
- Two joint letters from Director-General, WHO and Administrator, UNDP to UNCTs to UNCTs (2012 and 2014)

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• An organigram is available at http://www.who.int/nmh/publications/nmh-organigram-201409.pdf?ua=1

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Mental health and substance abuse

Background

Working in close collaboration with WHO Regional and Country Offices, the objectives of the Department of Mental Health and Substance Abuse (MSD) are to reduce the burden associated with mental and neurological disorders, including substance use disorders, and to promote mental health worldwide. The Department’s immediate strategic objectives include implementation of the Mental Health Action Plan 2013-2020 adopted by the World Health Assembly in 2013 and the implementation of the Global Strategy to Reduce the Harmful Use of Alcohol, adopted by the World Health Assembly in 2010.

Key messages

Comprehensive Mental Health Action Plan 2013-2020

The 66th WHA – through WHA 66.8- adopted the Comprehensive Mental Health Action Plan 2013–2020 outlining key responsibilities for WHO, member states and civil society

With respect to the Comprehensive Mental Health Action Plan, HWOs should:

- Encourage governments to revise policies, strategies and laws for mental health in line with international human rights standards and allocate appropriate resources for their implementation
- Promote an integrated approach to mental health advocating for the inclusion of mental health into general health, disability policies and strategies, and poverty reduction efforts.
- Encourage countries to integrate core mental health indicators (from the WHO Mental Health Atlas) into the health information system of the country
- Discourage governments from building psychiatric hospitals and actively encourage them to replace psychiatric hospitals with a network of services in general hospitals, primary care and the community.
- Make available and support the use of WHO quality and human rights standards for improving quality of care and human rights conditions in inpatient and outpatient mental health facilities
- Make available and support the use of the WHO mhGAP Intervention Guide for scaling up services for mental and neurological disorders in general health care.
- Advocate with countries to consider the inclusion of suicide prevention, early childhood development strategies, and actions against human rights violations as part of core multisectoral strategies for mental health promotion and prevention
- Know that the WHO MiNDBank provides policy makers, planners, NGOs, advocates and researchers with easy access to national level policies, strategies, laws and service standards (covering mental health, health, substance abuse, disability, human rights, children and adolescents) from around the world
**Humanitarian emergencies**

In large humanitarian emergencies, the interest of national and international agencies in mental health often increases dramatically. This can create increased responsibilities and opportunities for WHO Country Offices.

With respect to humanitarian emergencies HWOs should:

- Know that emergencies are a potent risk factor for mental health problems.

- Know that key mental health and psychosocial support (MHPSS) activities through the Health Cluster include: situation analysis, psychological first aid by health staff and community workers, front-line mental health care in general health care clinics, facilitating continued care and protection of vulnerable patients in mental institutions, and planning mental health system recovery.

- Consider that in large crises with numerous MHPSS actors, coordination of MHPSS may be best set-up through a MHPSS Cross-Cluster Technical Working Group with MHPSS focal points in each of the Health, Protection and Education Clusters and with accountability for MHPSS activities within the relevant Clusters.

- Consider using the emergency as an opportunity to build back a better mental health system, as has been done in many countries (WHO, 2013). WHO has a comparative advantage to other agencies to work with the government lead the development of sustainable mental health care after emergencies.

- Know that WHO’s views on the inter-sectoral organization of MHPSS in emergencies are reflected in the [Sphere Project](https://www.who.int/mens/standard/en/)’s standard on mental health and in IASC Guidelines.

**Psychoactive substance use**

The department’s mandate in the area of psychoactive substance use includes measurement, prevention and reduction of the negative health and social consequences of psychoactive substance use and developing norms and standards for the identification and management of substance use disorders.

With respect psychoactive substance use, HWOs should:

- Be familiar with the document: "WHO’s role, mandate and activities to counter the world drug problem a public health perspective", which describes WHO’s role, mandate and current activities related to the United Nations General Assembly Special Session (UNGASS) on the World Drug Problem.

- Make available and support the use of WHO guidelines developed in the area of substance use.

- Encourage governments to formulate or revisit policies and activities to reduce the harmful use of alcohol in line with the 2010 WHO Global strategy to reduce the harmful use of alcohol and make available tools, instruments and training material produced to build knowledge and capacity on this issue.

- Be aware that engagement with the alcohol industry at national level is at the discretion of each Member State, but advocate that the alcohol industry has no role in the formulation of alcohol policies, which must be protected from distortion by commercial or vested interests and that the engagement should be restricted to information sharing and consultations.
Facilitate the WHO Global Survey on Alcohol and Health and the ATLAS questionnaire on resources for the prevention and treatment of substance use disorders, which are key data-collection mechanisms regularly forwarded to all WHO Member States through the WHO regional and country offices for completion by focal points and national counterparts nominated by governments.

Resources

Mental health action plan

- WHO Mental Health Policy and Service Guidance Package (14 modules)
- World Health Organization (WHO) black dog video
  [https://www.youtube.com/watch?v=XiCniiLQGYc](https://www.youtube.com/watch?v=XiCniiLQGYc) (2012)
  [https://www.youtube.com/watch?feature=player_profilepage&v=2VRRx7Mtep8](https://www.youtube.com/watch?feature=player_profilepage&v=2VRRx7Mtep8) (2014)

Humanitarian emergencies

- Further resources on MHPSS in emergencies
- Substance abuse
- The Management of substance abuse website
- The WHO Global strategy to reduce harmful use of alcohol
- WHO’s role, mandate and activities to counter the world drug problem; a public health perspective
- The WHO Global status report on alcohol and health 2014
• Global Information System on Alcohol and Health (GISAH)
  http://www.who.int/gho/alcohol/en/
• Resources for the Prevention and Treatment of Substance Use Disorders
  http://www.who.int/gho/substance_abuse/en/

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Injury, violence, blindness and deafness, disability and rehabilitation

Background

**Injury and violence**

Every day the lives of more than 14,000 people are cut short as a result of an injury. Among the causes of injury are acts of violence against others or oneself, road traffic crashes, burns, drowning, falls, and poisonings. The deaths caused by injuries have an immeasurable impact on the families and communities affected, whose lives are often changed irrevocably by these tragedies.

Injuries and violence have been neglected from the global health agenda for many years, despite being predictable and largely preventable. Evidence from many countries shows that dramatic successes in preventing injuries and violence can be achieved through concerted efforts that involve, but are not limited to, the health sector. The international community needs to work with governments and civil society around the world to implement these proven measures and reduce the unnecessary loss of life that occurs each day as a result of injuries and violence.

**Blindness and deafness prevention, disability and rehabilitation**

Globally, the number of people of all ages who are visually impaired has been estimated to be 285 million, of whom 39 million are blind: people 50 years and older account for 82% of those who are blind. The first cause of blindness is cataract (51%) and the major causes of visual impairment are uncorrected refractive errors (43%), and cataract (33%). Overall, visual impairment is a major public health issue, especially since more than 80% of the causes of visual impairment can be treated or prevented.

It has been estimated that 360 million people live with hearing loss globally, and the majority of these hearing problems could have been prevented or treated. The major causes of hearing problems, are chronic ear infections, meningitis, rubella, noise and use of ototoxic medications, all of which can be addressed by means of well-known and generally accessible public health measures. The fact that over 1 billion teenagers and young adults are exposed to unsafe levels of sound, and that 43 million are already living with some level of hearing loss, underscores the importance of instituting hearing loss prevention programs.

WHO’s World Report on Disability estimates that there are more than a billion people with disabilities worldwide, or 15% of the world’s population, the majority of which live in low- and medium-resource countries. The prevalence of disability is rapidly rising because of the ageing population and the global increase in chronic disease conditions. Disability, moreover, disproportionately affects vulnerable populations of women, the elderly and the poor. The situation of people with disabilities worldwide is worsened not only because of limited access to health and rehabilitation services, but also because they face widespread barriers to accessing all social resources resulting in lower educational achievement, less economic participation and higher rates of poverty.

The treatment of hearing and vision threatening diseases and the prevention and rehabilitation of visual and hearing impairments is an essential public health intervention that can no longer be neglected. Planned strategies to treat the major causes of these impairments and to educate the general public on ways to
protect their hearing and vision functions can have an immediate and sustained positive health outcome at individual and community levels. WHO is also committed to improving the lives of all persons experiencing irreversible disability by identifying and removing barriers to full participation in all areas of life, and in particular to improve access to health and rehabilitation services that directly improves outcomes in education, employment, family, community and public life. Good health for persons with disabilities, moreover, is a major contributor to the achievement of broader global development goals.

**Key messages**

**Injuries and violence**

- Injuries and violence are overlooked aspects of public health — collectively they account for 1.7 times the number of deaths arising from HIV, TB and malaria combined, but they receive far less attention.

- Injuries and violence are particularly prevalent among children and young adults, tend to involve males more than females, and are more common within poorer countries and the poorer socio-economic groups within all countries.

- WHO coordinates, and provides Secretariat functions for, the UN Road Safety Collaboration, the Violence Prevention Alliance, and the Global Alliance for Care of the Injured.

- WHO is coordinator within the UN system for road safety and plays a pivotal role in the UN Decade of Action for Road Safety — a multisectoral framework to address road traffic injury.

- In response to a WHA resolution, WHO is currently developing a Plan of Action for the prevention of violence, following the 2014 launch of the Global Status report on violence.

**Blindness and deafness prevention, disability and rehabilitation**

- The global eye health action plan 2014–2019 aims to reduce avoidable visual impairment as a global public health problem and to secure access to rehabilitation services for the visually impaired, with the global target of reducing the measured prevalence of avoidable visual impairment by 25% by 2019.

- The priorities of the eye health action plan is to generate evidence on the magnitude and causes of visual impairment and eye care services to identify priorities for service development, to encourage the development of integrated national eye health policies, and to strengthen multisectoral partnerships to strengthen eye care provision.

- WHO recognises the need to respond to the global trend to an increasing incidence of chronic eye diseases related to ageing and to fully integrate eye care programmes into the wider health care system at all levels (primary, secondary, and tertiary).

- WHO recognises that since severe hearing loss constitutes a serious obstacle to optimal development, communication and education, Member States should develop national plans within the primary health care framework.

- It is apparent that there is a general lack of epidemiological data on hearing loss and its causes, as well as information concerning human resources devoted to ear and hearing care among Member States.
• It is also recognised that human resources for ear and hearing care are not equally distributed in the world and that therefore a more concerted effort needs to be directed to low and lower-medium income countries.

• In response to the recommendations of the World Report on Disability in 2011 and the recognition that disability is not merely a global public health issue, but a human rights and human development issue, the Executive Board approved the WHO global Disability Action Plan 2014-2021.

• The Disability Action Plan focuses on three key objectives: to remove barriers and improve access to health services; to strengthen and extend rehabilitation, and assistive technology services; and to strengthen the collection of relevant and internationally comparable data on disability.

HWOs should:

1. Be aware of the major normative documents WHO has made available on injury, violence, disability, blindness and deafness.
2. Be able to convey to national counterparts that these issues represent an important burden of mortality and morbidity, and are largely preventable.
3. Advocate for inclusion of these issues within exercises such as country cooperation strategies and national health programming, particularly since they represent a substantial public health burden but are frequently seen as non-traditional areas of public health, or non-health sector responsibilities.
4. Ensure qualified country office technical staff are responsible for covering these areas and can function as qualified focal points for Headquarter and Regional Office colleagues. Delegation of these areas to country office staff should bear in mind the importance of intersectoral arrangements to address these issues and therefore should take place ensuring the staff member is fully qualified to serve the area.

Resources

Prevention of violence

- Global status report on violence prevention 2014

- World report on violence and health

Unintentional injury prevention

- Global status report on road safety 2013

- World report on road traffic injury prevention

- World report child injury prevention

- Global report on drowning: preventing a leading killer

- Burn prevention: success stories, lessons learned
Care of the injured

- Strengthening care for the injured: success stories and lessons learned from around the world

Blindness and deafness, disability and rehabilitation

- Universal eye health: a global action plan 2014–2019
  http://www.who.int/blindness/actionplan/en
- Global data on visual impairment
  http://www.who.int/blindness/publications/globaldata/en/
- Multi-country assessment of national capacity to provide hearing care
  http://www.who.int/pbd/publications/WHOReportHearingCare_Englishweb.pdf?ua=1
- WHO global disability action plan 2014-2021
  http://www.who.int/disabilities/actionplan/en/
- World report on disability
- Community-based rehabilitation guidelines
  http://www.who.int/disabilities/cbr/guidelines/en/

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Nutrition as a foundation to health, sustainable development and the prevention of noncommunicable diseases

Background

Malnutrition in all its forms, including undernutrition, micronutrient deficiencies, overweight and obesity, not only affects people’s health and wellbeing by impacting negatively on physical and cognitive development, compromising the immune system, increasing susceptibility to both communicable and noncommunicable diseases like cancer, diabetes and cardiovascular diseases and chronic respiratory diseases, restricting the attainment of human potential and reducing productivity. Malnutrition in all its forms also poses a high burden in the form of negative social and economic consequences to individuals, families, communities and States as it also sharply contributes to increasing the gap in health inequalities. Malnutrition also plays a key role in the global epidemic of overweight and obesity, as well as in the rise in noncommunicable diseases. Estimates show that:

- chronic malnutrition as measured by stunting has declined, but in 2013 still affected 161 million children under five years of age, while acute malnutrition (wasting) affected 51 million children under five years of age;
- undernutrition was the main underlying cause of death in children under five, causing 45% of all child deaths in the world in 2013;
- over two billion people suffer from micronutrient deficiencies, in particular vitamin A, iodine, iron and zinc, among others;
- overweight and obesity among both children and adults have been increasing rapidly in all regions, with 42 million children under five years of age affected by overweight in 2013 and over 500 million adults affected by obesity in 2010;

The root causes and factors leading to malnutrition in all its forms are complex and multidimensional. Therefore, coherent policies and coordinated actions across all relevant sectors are needed to improve nutrition. Nutrition policies should promote a diversified, balanced and healthy diet at all stages of life. In particular, special attention should be given to the first 1,000 days, from the start of pregnancy to two years of age, pregnant and lactating women, women of reproductive age, and adolescent girls, by promoting and supporting adequate care and feeding practices, including exclusive breast feeding during the first six months, and continued breastfeeding until two years of age and beyond with appropriate complementary feeding. Nutrition improvement requires healthy, balanced, diversified diets to meet nutrient requirements while avoiding the excessive intake of saturated fat, sugars and salt/sodium, and virtually eliminating trans-fat. Healthy diets should be fostered in preschools, schools, public institutions, at the workplace and at home.

Health systems need to be strengthened and universal health coverage needs to be promoted, particularly through primary health care, to enable national health systems to address malnutrition in all its forms while providing access for all to integrated health services through a continuum of care approach, including
WHO’s work on nutrition encompasses identifying or creating the best available evidence on human nutrition and related interventions in order to develop its normative work (e.g. guidelines), provide policy advice to Member States and build tools for assessment, surveillance and monitoring of human nutrition from a public health perspective at global, regional and local level. Nutrition is a cross cutting theme for the Organization’s six categories of work and programme areas as food and nutrition play a major role in both communicable diseases and noncommunicable diseases, and adequate nutrition is central to effectively promoting health through the life-course starting at early ages and especially for vulnerable populations. Nutrition interventions require strong health systems and a health systems perspective. Moreover, appropriate nutrition work is central to ensure that populations exposed to disease outbreaks and acute public health emergencies get food in adequate quantities and qualities so their situation is not worsened by inappropriate food provision. Therefore, WHO’s work on nutrition at the three levels, HQ, Regional Offices and Country Offices contributes to the Organization’s leadership and corporate services.

Key messages

- WHO’s work on nutrition is articulated with the Organization’s six core functions set out in the 12th General Programme of Work: leadership, research, setting norms and promoting their implementation, articulating ethical and evidence-informed policy options, providing technical support and monitoring health situation and trends.

- Malnutrition remains one of the world’s most serious but least addressed health problems and a significant contributor to child mortality. Nearly one-third of children in low-income countries are either underweight or stunted, and more than 30% of people living in low-income countries suffer from micronutrient malnutrition. Food and nutrition are important features of the sustainable development goals.

- Malnutrition undermines economic growth and perpetuates poverty; and its human costs are enormous.

- The epidemic of obesity and noncommunicable conditions is now common to almost all countries. Many low-income countries have started to suffer from a double burden of undernutrition and obesity. High-income countries enjoy advanced welfare systems and high quality of life, but face malnutrition in ageing populations and obesity rates and rising noncommunicable conditions.

- As the global authority in public health, WHO works to tackle the medical aspects of illness and adverse health conditions, but also the social determinants of ill health and the promotion of health as a positive outcome of policies in other sectors. In 2011 the World Health Assembly has adopted a Comprehensive Implementation Plan to achieve six global nutrition targets by 2025 nutrition interventions and multisectoral actions in the food system, education and social protection: reducing low birth weight; stunting, wasting and overweight in children; promoting exclusive breastfeeding in the first six months of age, and halving anaemia in women. A tracking tool has been built to aid Member States monitor their progress.

- Normative work on nutrition, in the form of guidelines, is a cross-cutting issue with regard to all categories of work in WHO. Such is the case, for instance, of nutritional care of persons suffering
from a communicable diseases (e.g. malaria, Ebola, persons living with HIV, with active TB or those living in malaria endemic areas) and the nutritional care of persons suffering from noncommunicable conditions (e.g. diabetes, obesity, cancer or cardiovascular disease). WHO has established dietary goals and defined healthy diet. Moreover, normative work includes evidence-informed recommendations for Member States on interventions to improve infant and young child feeding (breastfeeding and complementary feeding) and adequately prevent and treat micronutrient deficiencies (e.g. iron, zinc, vitamins, iodine, or calcium) for different population groups (e.g. infants, school age children, pregnant women or women of reproductive age).

- WHO has developed tools to implement policies and programmes, such as training courses on nutrition, manuals on how to develop food based dietary guidelines and evaluation of nutritional quality of foods (nutrient profiling), child growth standards, briefs on policy options to improve nutrition.

- WHO advocates for the inclusion of nutrition in Development Assistance Frameworks, provides support to the establishment of multisectoral nutrition policies and related coordination mechanisms, transfers knowledge and provides technical support on how to implement essential nutrition interventions through the health system and other delivery channels, helps strengthening capacities of managers and health workers in nutrition, supports the establishment of monitoring systems.

- WHO works jointly with other UN Agencies dealing with nutrition (FAO, UNICEF, WFP) through a global coordination mechanism (UN Standing Committee on Nutrition) and a country joint support mechanism (REACH). Joint programming is highly encouraged.

- Normative work and programme guidance covers both stable and emergency settings, including outbreak. In emergencies WHO supports nutrition surveillance, screening of malnourished children and treatment of acute malnutrition through health facilities and the community.

- WHO’s work on nutrition seeks to achieve the Organization’s key outcome (increased access to health services or reduction of risk factors) and eight impact goals as set out in the 12th General Programme of Work.

Resources

The Department of Nutrition for Health and Development of WHO provides Member States and the global community with the best quality evidence on interventions to improve nutrition at population level, databases of policy and implementation experiences, and a list of current WHO guidelines on nutrition-related topics. Technical support to countries is guaranteed through a network of regional advisors and dedicated nutrition staff placed in intercountry support teams and in country offices.

- WHO nutrition website
  www.who.int/nutrition/en/
- Comprehensive implementation plan on maternal, infant and young child nutrition (including WHA65/6)
  www.who.int/nutrition/publications/CIP_document/en/
- Global Targets 2025 to improve maternal, infant and young child nutrition
  www.who.int/nutrition/global-target-2025/en/
- The WHO electronic Library of Evidence for Nutrition Action (eLENA)
  www.who.int/elena/en/index.html
Global database on the Implementation of Nutrition Action (GINA)
www.who.int/nutrition/gina/en/

The child growth standards
www.who.int/childgrowth/en/index.html

The nutrition databases
www.who.int/nutrition/databases/en/

Nutrition publications (including, for instance, guidelines and systematic reviews)
www.who.int/nutrition/publications/en/

Global Nutrition Report 2014

Healthy diet factsheet 2015
www.who.int/mediacentre/factsheets/fs394/en/

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International Health Regulations (IHR) 2005

Background

The International Health Regulations (2005) (IHR) are a global agreement against the international spread of disease through defined Core Capacities to prevent, detect and respond at the national and international levels. The IHR are legally binding to all WHO Member States – and having entered into force since 2007, they provide a single framework for preventing, detecting, reporting, and responding to acute public health events of potential international concern.

The IHR mandate guides the establishment and strengthening of core capacities for public health surveillance, assessment and response. Including IHR core capacity strengthening within the overall functioning of their health systems will enable Member States to maintain sustainable and country-specific measures against the international spread of disease that build on the key components of national policies, structures and plans. The IHR provide clear timelines and deadlines for countries in meeting their Core Capacity requirements.

The scope of the IHR (2005) includes almost any serious public health risk which can be transmitted internationally, whether biological, chemical, radio-nuclear or as yet unknown in origin, and whether transmitted by persons, food/animals, vectors or the environment.

Within Member States, events that shall be notified to WHO under IHR are those that are either assessed as serious, as unusual or unexpected, as carrying a risk of international spread, or as posing risks to international travel or trade. In addition, certain diseases shall always be notified under the IHR. Subject to such criteria, the notification of public health events to WHO is mandatory under international law.

In the management of acute public health events, IHR require for all WHO Member States:

- a National IHR Focal Point for urgent communications with WHO and other Member States at all times
- notification and verification to WHO of outbreaks and other public health events
- compliance with rules for applying health measures to international travellers, trade and transport (e.g. examinations, vaccinations, inspections, quarantine)
- public health facilities and services at international ports, airports and ground crossings (“points of entry”)

Within this framework, WHO has a central role in supporting countries in preparing for and managing public health events and emergencies.

All WHO Regional Offices have an IHR Contact Point available on a 24-hour basis for IHR-related communications, including notifications to WHO and requests for support to respond to events. The WHO Country Office is key for communications and support to the national authorities responding to events.
Key messages

Public health events and emergencies

- Increase awareness of the country’s rights and obligations under IHR, within the MOH and other government agencies.

- Building national capacity within existing health system reform or strengthening is the best way to prevent international spread of diseases. Almost all Member States are working to achieve the required capacities by 2016 (if not achieved earlier), including implementation plans and assessments. Support for countries in planning and achieving these goals is critical.

- Incorporating mechanisms for strengthening IHR Core Capacities into Country Cooperation Strategies will help WHO Country Offices in promoting Member State compliance with its obligations under IHR.

- Be familiar with the guidance on the assessment and monitoring of the required national public health capacities for surveillance, investigation, reporting and response to health threats and emergencies. These can guide and drive preparations for health emergencies.

- Advocate for the critical role and active participation of the country’s designated National IHR Focal Point in multisectoral preparedness for health events and emergencies and in sharing urgent information during a public health event of potential international concern.

- Ensure a good relationship between WHO and the National Focal Point. This will be critical to ensuring transparent and timely information to support the risk assessment of public health events both nationally and globally.

- Seek additional support from the Regional Office’s IHR team, and the HQ Department for Global Capacities, Alert and Response (GCR) to ensure WHO meets its obligation to respond to requests for support concerning the response to public health risks. The HWO is responsible for identifying and responding the country’s requests for support — and for communicating unmet needs to ROs and HQ, who will respond to requests that cannot be met by the Country Office.

- Facilitate the timely exchange of event-related information between the national authorities and the WHO Secretariat in order to ensure WHO effectively fulfils its mandate to assess risks, provide the international community with timely and accurate information about public health events and support to countries.

Resources

- International Health Regulations (available in Arabic, Chinese, English, French, Russian, Spanish) http://www.who.int/ihr/publications/9789241596664/en/
- IHR Website: http://www.who.int/ihr/ and training platform at https://extranet.who.int/ihr/training/
Contacts

WHO has designated Regional Contact Points to be accessible at all times for communications with the IHR National Focal Points

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WHO headquarters

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- Alert and Response Operations: outbreak@who.int
- Global Preparedness, Surveillance and Response: Dr Stella Chungong, chungongs@who.int
- IHR Capacity Assessment, Development & Maintenance: Dr Florence Fuchs, fuchsfl@who.int
Emergency risk management

Background

Health security, emergency risk management for health, WHO readiness and response to emergencies are part of WHO’s core business.

Two WHA resolutions provide the basis for WHO’s actions in emergencies:

- Resolution WHA 65.20 gives a clear mandate for WHO to fulfil its role in international emergency response including as cluster lead agency
- WHA 64.10 provides the policy basis for WHO’s role in supporting Member States to strengthen country capacities for emergency risk management for health – including prevention, preparedness, response and recovery.

Key messages

Newly appointed HWOs should:

- Be familiar with the Emergency Response Framework (ERF) which outlines a common approach for WHO’s response to emergencies and clarifies roles and responsibilities at each level of the organization. Specifically, WHO’s critical functions in emergency response, as outlined in the ERF are:
  - Leadership/coordination of the health sector
  - Information management for appropriate action
  - Technical expertise appropriate to the health needs of the emergency
  - Core services to support health response (administration, grant management, logistics, procurement etc.)
- Ensure WHO country office readiness to effectively fulfil the critical functions in response to an emergency, guided by the WHO readiness checklist.
- Be familiar with the principles for effectively managing the public health risks of emergencies, including adoption of all hazards and multisectoral approaches. These principles are outlined in the document Emergency Risk Management for Health: Towards a new global framework.
- Provide WHO strategic and technical support to national emergency risk management for health programmes.
- Understand WHO’s roles and responsibilities as Health Cluster Lead Agency, as affirmed by resolution WHA 65.20 and specified in the Health Cluster Guide.
- Understand WHO’s role as a member of the UN Humanitarian Country Team (UNHCT) and our obligations to collective action and collective results.
Resources

- WHA 65.20 on WHO’s response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies
- WHA 64.10 on Strengthening national health emergency and disaster management capacities and resilience of health systems
  www.who.int/gb/ebwha/pdf_files/WHA64/A64_R10-en.pdf
- The Emergency Response framework (ERF)
- Health Cluster Guide
- IASC Level 3 protocols
- Emergency Risk Management for Health: Towards a new global framework
  Guidance for integrating health emergency risk assessment, capacity assessment and WHO readiness for response into the Country Cooperation Strategy

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Essential medicines and health products

Background

Essential medicines and health products include medicines, vaccines, biological and blood products, diagnostics and medical devices. They represent a fundamental component of both modern and traditional medicine. They need to be safe, effective, of good quality, affordable and they need to be prescribed and used rationally. Access to essential medicines and medical products, as part of the right to the highest attainable standard of health, is well-founded in international law. Further, access to medicines is included in the Millennium Development Goals as well as in the Sustainable Development Goals SDGs as they are currently framed for UN 2016.

Improving access to safe and affordable medicines is a core principle underpinning Universal Health Coverage Strategy and one of the six leadership priorities of WHO.

Essential Medicines and Health Products Department

The Essential Medicines and Health Products Department (EMP) at WHO Headquarters is part of the Cluster of Health Systems and Innovation (HIS). EMP provides normative and technical guidance, as well as leadership and technical collaboration to countries to help expand global access to medical products within the wider framework of UHC and in support of priority health programmes (HIV/AIDS, TB, malaria, MCH-reproductive health) and NCDs.

WHO/EMP implements the Prequalification Programme, a UN programme managed by WHO that helps ensure that medicines, vaccines, diagnostics and medical devices supplied by international procurement agencies meet acceptable standards of quality, safety and efficacy. Every year, around USD$1 billion worth of medicines are purchased by or through international procurement agencies (such as GAVI UNICEF, UNITAID, PAHO Revolving Funds and the Global Fund to Fight AIDS, Tuberculosis and Malaria) for distribution in resource-limited countries.

As outlined in WHA60.29, the EMP Department aims to ensure improved access, quality and use of safe and appropriate medical devices. Medical devices are essential for safe and effective prevention, diagnosis, treatment and rehabilitation of illness and disease. The achievement of health-related development goals, including the MDGs, are contingent upon proper manufacturing, regulation, planning, assessment, acquisition, management and use of medical devices which are of good quality, safe and compatible with the settings in which they are used.

EMP is the Secretariat of WHO Expert Committee (EC on Selection and Use of Medicines (EML); EC on Drug Dependence; EC on Specifications for Pharmaceutical preparations; EC on Biological standardization; INN Consultations).

EMP is divided into three teams:

- Policy, Access and Use (PAU): provides guidance and supports countries on the selection of essential medicines, improvement of the use of medicines/medical products and promotion of comprehensive national medicines policies and good governance. PAU also provides guidance and works with countries on affordable prices and sustainable financing, procurement and supply mechanisms.
• **Public Health, Innovation and Intellectual Property (PHI):** promotes a public health-driven research and development agenda, and stimulates innovation in the discovery, development, production and delivery of essential health technologies. PHI works on the interface between public health, innovation, research, transfer of technology and intellectual property.

• **Regulation of Medicines and other Health Technologies (RHT):** supports the provision and promotion of quality, safety and efficacy norms and standards; provides technical assistance for regulatory systems strengthening, and regulatory networking and convergence efforts; runs the prequalification programme for priority medicines, vaccines and diagnostics; and works with countries on safety monitoring and vigilance of medical products, including the SSFFC agenda.

Since the declaration of the Ebola outbreak in August 2014, WHO has led a series of consultations and high-level meetings with key experts and stakeholders on the research, development, regulation and funding of potential medical solutions for Ebola. EMP provided continuous inputs to WHO Response and Research and Development Team, mobilizing expertise and resources to deploy staff in affected countries. At the same improving the procurement and supply of medical products, and setting up proper policies and systems on medical products is a critical element in building the health sector in the Ebola-affected countries.

**Key messages**

**Major challenges faced in the area of EMP**

• Access to essential medicines and medical products remains a serious problem in low and middle income countries (and also in some high income countries). In most LMIC, between 25-60% of total health expenditures is on medicines and medical products, and often >80% is out-of-pocket payment. Consequently, access to and proper use of quality-assured essential medicines is a critical element for UHC, as well as for any of the disease-oriented programmes, i.e. HIV/AIDS, TB, malaria, reproductive and mother/child health, as well as NCDs.

• The overuse, underuse or misuse of medicines harms people and wastes resources. Problems include: poly-pharmacy (use of too many medicines); overuse of antibiotics and injections resulting in antimicrobial resistance; failure to prescribe in accordance with clinical guidelines; inappropriate self-medication; lack of paediatric formulations.

• The lack of availability of medicines for priority programme (HIV/AIDS, TB, malaria, reproductive health and mother/child health, as well as NCDs and mental health) is still of major concern. The access and affordability to medical products for these diseases will continue to be a priority in the post-2015 development agenda.

• High prices of innovative medicines and medical products are one of the barriers to improving access. Most health problems can be addressed by low-cost generic medicines, but often in non-competitive markets the prices of these generics remain high. The prequalification of medicines, vaccines, diagnostics and certain medical devices for these priority areas for international procurement has been a critical factor in increasing availability of quality-assured low-cost generics.

• Global production and distribution of medicines carries the risk of spurious/falsely-labelled/falsified/counterfeit medicines (SSFFC). Due to global trade and increasing complexity of many medi-
cal products, as well growing expectations in the population, ensuring the quality of these products is becoming increasingly challenging. SSFFC products range from random mixtures of harmful toxic substances to inactive, ineffective preparations. The source of a SSFFC medicine is generally unknown, its content unreliable and its use can result in treatment failure or even death. SSFFC medicines are always illegal. Eliminating them is a considerable public health challenge.

- WHO is responsible for normative work and standard setting for medicines, vaccines and diagnostics through its Expert Committees and expert groups (the Expert Committees on biological standardization and on specifications on pharmaceutical preparations; the INN expert group; and the experts groups on safe medicines and vaccines); and provides global guidance on medicines selection through the Expert Committee on Essential Medicines.

- Access to essential medicines that are controlled under UN conventions (narcotic and psychotropic substances) is often limited, especially in developing countries. These conventions have been established to prevent abuse, dependence, harm and illicit drug trafficking, while recognizing the need to make psychotropic and narcotic substances available for medical and scientific use.

**Areas where WHO/EMP makes a difference**

- Providing policy guidance and support to countries to develop, implement, monitor and evaluation national policies and strategies on medical products that aim to expand access to medical products within the wider framework of UHC.

- Implementing the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property, including policies on local production of medical products, and stimulating a public-health driven research and development agenda.

- Providing global guidance on medicines selection through the Expert Committee on essential medicines and on methodologies and processes for medicines selection, including the use of HTA; this also includes independent prescriber information based on the WHO Model List of Essential Medicines (including Children EML).

- Providing global guidance and information on the pricing of medical products, supporting countries in monitoring prices of these products, and working with countries to put in place national strategies and policies on prices of innovator medicines, as well as on creating competitive generic markets.

- Raising awareness and stimulating action to improve the access to and rational use of safe, effective, quality medical products.

- Supporting the strengthening of regulatory systems of medicines, vaccines and other health technologies that contribute significantly to i.) the availability of efficacious, good quality, and safe medical products, and ii.) the prevention and detection of SSFFC medicines.

- Promoting networking, coordination of partners in the field, coordination with many WHO Collaborating Centres.
Resources

➢ EMP website: http://who.int/medicines/areas/en/
➢ Prequalification website (contains public information related to medicines/vaccines/diagnostics prequalified, inspection reports, dossier assessments, quality control labs, etc.) http://apps.who.int/prequal/
➢ EMP Information Portal (facilitates access to most publications in the area of pharmaceuticals and health products) http://apps.who.int/medicinedocs/en/q/
➢ Most relevant publications and resolutions related to pharmaceuticals http://who.int/medicines/publications/en/
➢ PowerPoint presentations related to key topics can be requested from EMP Director Kees De Joncheere or Christophe Rérat (reratc@who.int)

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An EMP Organizational Chart is available at: http://intranet.who.int/homes/emp/
Social Determinants of Health

Background

Despite major improvements in life expectancy and health outcomes globally, health inequities remain a significant — and in many cases growing — challenge. While individuals naturally differ in their health profiles, health inequity refers to *avoidable, unfair* systematic differences in the health of populations. Health inequities are rooted in the social determinants of health (SDH) — that is, the conditions in which people are born, grow, work, live, and age.

Health equity and social determinants are acknowledged as a critical component of the Post-2015 and sustainable development global agendas and of the push towards progressive achievement of universal health coverage (UHC). If health inequities are to be reduced both SDH and UHC need to be addressed in an integrated and systematic manner.

The SDH/PHE Unit is responsible for coordinating WHO support to countries in the implementation of the *Rio Political Declaration on the SDH* (resolution WHA65.8). To this end, it leads the integration of the *social* component of the 12th GPW Leadership Priority on “addressing the social, economic, and environmental determinants of health as a means to promote health and reduce health inequities within and between countries” into WHO programmes and initiatives.

The SDH Unit works to support, guide and strengthen the capacities of countries to develop, implement, monitor and evaluate initiatives to promote health equity through addressing the SDH.

The team currently focuses on three areas:

1. Improved country and regional policies and capacities for intersectoral actions (including through a Health-in-All-Policies approach) and health programme reorientation to address the SDH and reduce health inequities through training and technical support;
2. Technical guidance on important policy linkages between social and environmental health determinants, and between social and health policies;
3. Monitoring trends and progress on action on the SDH and health equity, including within the universal health coverage framework, the sustainable development goals and the post-2015 development agenda.

Key messages

*Working across sectors: Implementing Health in All Policies for improving health equity*

A lack of policy coherence across government can result in one part of government supporting the implementation of international treaties, like the WHO Framework Convention on Tobacco Control, while other parts of the government promote trade that is harmful to health. One reason that these inconsistencies arise is because of a lack of understanding across sectors of the linkages between health (and quality of life), on the one hand, and the broader health determinants, including economic growth, on the other.
To contribute to policy coherence across government, the health sector needs to understand the imperatives of other sectors and form common understandings of health, its determinants and broader societal well-being or quality of life.

In practice this means engaging in several different actions, including:

• supporting workshops of government policy-makers, programme leaders and health provider groups to improve coherence in policies, services and programmes responding to disadvantaged groups’ needs;

• implementing workshops at different administrative levels and with government and private providers.

**Mainstreaming equity, SDH, gender and human rights into public health programmes for reducing health inequities**

To be effective, health services need to be tailored to the needs of specific population groups. Different social groups in the population differ in their empowerment to take up health interventions, due to the accumulation of disadvantage across many areas and the life course. Many public health programmes don’t have or are not reaching their health equity goals. This is the result not only of lack of health care specific interventions but also of failing to reach marginalized populations and to address key social determinants relevant to the public health issue.

With that in mind WHO is providing country support to promote the integration of equity, social determinants, gender and human rights in national health programmes (joint SDH-GER initiative). This work, in collaboration with national authorities and other partners, aims at closing coverage gaps, tackling health inequities and determinants, and applying a human-rights-based-approach through a “Step-wise methodology for reviewing how national health programmes can better account for equity, social determinants, gender and human rights”.

This methodology engages a multi-disciplinary review team from national and subnational health authorities, research institutes and academia, civil society and the multilateral system. Drawing from quantitative and qualitative data, it analyses:

• who is not accessing/benefitting from the programme;

• the barriers that different subpopulations face;

• the causes of those barriers (intermediate and structural determinants);

• the role of intersectoral action and social participation in overcoming access barriers;

• the potential ways a programme can be redesigned to better address access barriers; and

• ways to adjust the routine planning, review and M&E cycles of the programme to address inequities on an ongoing basis.
Enhancing pro equity linkages between social and environmental determinants of health

There are significant socio-demographic inequalities in both exposure to and negative health outcomes arising from adverse environmental conditions. At the WHO HQ level, social determinants of health have been strategically aligned with environmental determinants of health and currently new concrete approaches and projects are being developed to streamline social and environmental determinants in technical work.

As a first step towards stronger integration of social determinants of health within environmental health work, the following approaches are being followed:

- Identification of priority areas based on evidence, available tools and global commitments: Housing and health, water and sanitation, air pollution
- Stronger integration of social determinants in existing activities and tools, beginning with the WHO Housing and health guidelines (under development); GLAAS report on water and sanitation; Health protection in nuclear emergencies and the Environmental Burden of Disease;
- Development of concrete project proposals focusing on social determinants of environmental health risks, including:
  - “Guidance document identifying best strategies for, and health co-benefits of, housing interventions relevant to slums and other informal settlements”
  - “Collection of case studies on healthy housing interventions, model housing legislations and regulations with a high-equity co-benefit”
  - “Developing a framework for monitoring environmental health inequalities in countries” in the context of the “Equity-oriented analysis of linkages between health sector and other sectors” and the post 2015 sustainable goals discussion

Monitoring and measuring health determinants/barriers to improve health and access to health services for disadvantaged groups

In order to close health gaps, it is particularly important to consider the quality of health services experienced by disadvantaged populations. Health determinants change the environment and thereby structure individuals’ health behaviours, their participation in health programmes as well as their incentives to safeguard health. Therefore, data on health inequalities and the influence of social determinants on health inequalities is critical to inform evidence-based programming and policies.

In practice this means engaging in several different actions to identify the causes of those barriers (linked to working across all sectors and mainstreaming equity, SDH, gender and human rights).

Among these, one relevant action countries can take is to improve monitoring health determinants/barriers by:

- developing indicators to monitor programme effectiveness and quality for disadvantaged populations relative to average effectiveness and quality;
- assessing trends in health determinants for strategic prioritization of health interventions and intersectoral actions tailored to address the social gradient in health.
Resources

These and other relevant resources can be found at: [www.who.int/social_determinants/en](http://www.who.int/social_determinants/en)

Working across sectors; implementing Health in All Policies for improving health equity

- **Health in All Policies Training Manual** (WHO 2015) describes how to run short courses to improve intersectoral public health skills. Short courses can be used as workshops that promote intersectoral dialogue between health and other policy areas. The manual can be found at: [http://apps.who.int/iris/bitstream/10665/151788/1/9789241507981_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/151788/1/9789241507981_eng.pdf?ua=1).

- The **Social Determinants of Health Sectoral Briefing Series** (2011-2014) summarizes global evidence on the linkages between environmental and social factors influencing health outcomes by government policy sector. Thematic briefs can be found at the following links:
  - Housing: [http://apps.who.int/iris/handle/10665/44705](http://apps.who.int/iris/handle/10665/44705)
  - Social Protection: [http://www.who.int/iris/handle/10665/44876](http://www.who.int/iris/handle/10665/44876)
  - Energy: [http://www.who.int/iris/handle/10665/91591](http://www.who.int/iris/handle/10665/91591)
  - Education: [http://www.who.int/iris/handle/10665/44737](http://www.who.int/iris/handle/10665/44737)
  - Transport: [http://www.who.int/iris/handle/10665/44749](http://www.who.int/iris/handle/10665/44749).

- **Social Determinants of Health and Health Inequalities: a resource book** (WHO 2013) describes how to develop economic arguments and evaluations to motivate for interventions addressing health determinants. It also summarizes evidence on the intersectoral benefits of interventions addressing education, social protection, and urban infrastructure. The resource book can be found at: [http://apps.who.int/iris/bitstream/10665/84213/1/9789241548625_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/84213/1/9789241548625_eng.pdf?ua=1)

- **Health in All Policies with an equity lens**: WHO completed a Rockefeller-supported project supporting country discussions of health in all policies, and analysis of case studies, in lead-up to the 8th Global Conference on Health Promotion and the Resolution WHA67.12 (*Contributing to social and economic development: sustainable action across sectors to improve health and health equity*). Several reports documenting these discussions and associated research are provided under “Supporting regional positions on Health in all Policies” under the Publications section of the social determinants web site. Three synthesis papers analysed the equity lens of intersectoral actions and Health in All Policies and provide useful policy perspectives on addressing the social determinants of health inequities:
  - Practising a health in all policies approach: lessons for universal health coverage and health equity: a policy briefing for ministries of health based on experiences from Africa, South-East Asia and the Western Pacific: [http://apps.who.int/iris/bitstream/10665/105529/1/9789241506632_eng.pdf?ua=1&ua=1](http://apps.who.int/iris/bitstream/10665/105529/1/9789241506632_eng.pdf?ua=1&ua=1).
Demonstrating a health in all policies analytic framework for learning from experiences: based on literature reviews from Africa, South-East Asia and the Western Pacific

http://apps.who.int/iris/bitstream/10665/104083/1/9789241506274_eng.pdf?ua=1&ua=1

Moving towards health in all policies: a compilation of experience from Africa, South-East Asia and the Western Pacific

http://apps.who.int/iris/bitstream/10665/105528/1/9789241506595_eng.pdf?ua=1&ua=1

Mainstreaming equity, SDG, gender and human rights into public health programmes for reducing health inequalities

- WHO (forthcoming). 5-step review of national health programmes: To strengthen the focus on equity, social determinants of health, gender and human rights. Training manual. [Contact below focal points for further information.]
  http://apps.who.int/iris/bitstream/10665/85689/1/9789241505567_eng.pdf

Enhancing pro-equity linkages between social and environmental determinants of health

- Housing and health guidelines
  http://www.who.int/hia/housing/en/
- The Social Determinants of Health Sectoral Briefing Series (2011-2014)
  - Housing
    http://apps.who.int/iris/handle/10665/44705
  - GLAAS
  - Example from WHO Regional Office for Europe:

Monitoring and measuring health determinants/barriers to improve health and access to health services for disadvantaged groups

- Monitoring Health Determinants for Equity (WHO forthcoming) identifies indicator areas for monitoring societal factors influencing health service access and utilization, incentives for health behaviours and areas for health promotion interventions
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Ageing and life course

Background

The proportion of older people in the population is increasing in almost every country. By 2050, around 2000 million people in the world will be aged 60 years or over, with 400 million aged 80 years or over. Of them, 80% will be living in what are now low- or middle-income countries.

The transition to older populations will challenge society in many ways. Demand for health care, long-term care, social care and pensions are likely to increase, while the proportion of the population in traditional working ages will fall. But population ageing also presents many opportunities. Older people make important social contributions as family members, volunteers and active participants in the workforce. Indeed, older populations represent a substantial, but as yet underutilized, human and social resource.

Health in older age will be a crucial determinant of where the balance will lie between the costs and benefits associated with population ageing. Poor health undermines the ability of older people to remain actively engaged in society, limits their contribution and increases the costs of population ageing. Investing in health across the life course lessens the disease burden in older age, fosters the ongoing social engagement of older people (helping to prevent isolation) and has broader benefits for society by enabling the multiple contributions of older people.

Health and social systems and environments

Current health systems, particularly in low- and middle-income countries, are not adequately designed to meet the chronic care needs that arise from this complex burden of disease. These needs span the life course and the care continuum: from prevention to detection, early diagnosis, treatment, rehabilitation, long-term care and palliative care. In many places, health systems will need to move from focusing on the delivery of curative interventions for single acute problems to a more comprehensive continuum of care that links all stages of life and deals with multiple morbidities in an integrated manner.

Towards the end of life, many people will eventually require assistance beyond that habitually required by a healthy adult. Most of these individuals prefer this “long-term care” to be provided in their home, and this is often delivered by family members. For those with severe functional decline, institutional care may be required. There are few standards or guidelines on the most appropriate care, family carers often lack an understanding of the challenges they face, and care may be disconnected from health services. This can leave the needs of the older person inadequately addressed, with carers facing a greater burden than is necessary and acute care services being inappropriately used to fill gaps in chronic care. Furthermore, changing social patterns mean that it may not be sustainable to rely on families alone to meet many of these needs. The relative number of older family members is dramatically increasing; older people are less likely to live with younger generations and are more likely to express a desire to continue living in their own home; and women, the traditional family carers, may have changing career expectations. New systems of long-term care are therefore urgently required, to provide a continuum of care that is tailored to a continuum of need. These should be focused on the individual, closely linked to health systems and designed to maintain the best possible function, well-being and social participation.
Ageing and life course at WHO

The Department of Ageing and Life Course was initiated to explore the challenges and opportunities created by ageing populations around the world. As such, the Department is focusing on areas such as changes to health and social systems to respond to the health needs of ageing populations; supporting evidence informed policy development in countries; promoting age-friendly environments; and supporting research and monitoring on ageing and health. The WHO programme focuses in particular on promoting knowledge translation, engaging with technology and innovation to generate solutions for an ageing world, and building up a health workforce with the skills to handle age-related concerns.

Key messages

Advocacy

• Population ageing is one of the biggest demographic transitions the world has ever faced. Good health is central to ensuring that social and economic benefits are fully realized, and the development of sustainable health and social care systems is crucial if costs are to be controlled. There is a need for powerful international and national advocacy to ensure that the centrality of health is understood and that the opportunities arising from it are fully appreciated. As a step towards this goal, World Health Day 2012 had the theme “Good health adds life to years”, to bring global attention to bear on issues related to ageing and health. The Secretariat continues to convey these messages in many forums, but these perspectives need to be given even greater prominence in global development and research agendas.

Convening and coordinating

• The Secretariat partners with many other organizations, including the International Association of Gerontology and Geriatrics and the International Federation on Ageing, to link experts and decision-makers in this field. A more formal expert advisory mechanism to inform the Director-General and other stakeholders about key knowledge gaps and priorities for research and action in the field of ageing and health is being established.

• The WHO World Report on Ageing and Health will be launched in October 2015. A comprehensive global strategy on ageing and health, followed by a global ageing and health action plan with measurable outcomes to shape future global priorities in this area will follow.

Support to Member States

• The Secretariat currently supports Member States by providing guidance on key issues and promoting uptake of this evidence into policy and action at country level. This work is carried out by all levels of the Organization. The project on “Knowledge translation on ageing and health” supports Member States in identifying priorities for action and developing evidence-based policy options. The approach was piloted in Ghana in 2013 and China in 2014 and 2015. The Secretariat is also working to support the development of physical and social environments that foster active and healthy ageing through the WHO Global Network of Age-friendly Cities and Communities. This network encourages the exchange of experience and mutual learning between cities and communities that are creating
inclusive and accessible “age-friendly” environments. It currently has over 150 member cities and communities in 21 countries worldwide, as well as 10 affiliated country programmes.

- However, more support is needed. This includes:
  - defining the best steps that countries at different levels of development can take to build older person centred and integrated care spanning primary health care, long-term care and end-of-life care;
  - identifying evidence-based strategies to create environments that foster healthy and active ageing and enable intergenerational collaboration;
  - developing models and standards for monitoring and quantifying the health of older people;
  - elaborating strategies for capacity-building and workforce development to address the health needs of older people;
  - identifying sustainable financing models to ensure access to services.

Knowledge generation and management

- WHO will release the clinical guidelines on integrated care for older people (ICOPE) in 2015. Support will be required for the roll out in countries. These guidelines facilitates the organization of service delivery at country level

- WHO will release the first global report on ageing and health in 2015. This will constitute a crucial resource for Member States, defining what is currently known, outlining case studies of innovative responses and making clear the gaps in our knowledge. Nonetheless, there is an urgent need to ensure that these knowledge gaps are included in global research agendas.

- As a first step, data gathered by the Organization needs to be collected across the whole life course and disaggregated by sex and age, to distinguish between different stages of ageing. The standards and practices recommended by WHO for data collection by Member States should also promote disaggregation by sex and age across the whole life course. Furthermore, objective indicators are urgently needed for monitoring the health of older adults, including determinants and consequences, and encouragement should be given to research that identifies the most cost-effective interventions.

Resources

All publications can be found at the departmental website: www.who.int/ageing/en
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Gender, equity and human rights

Background

Recognising that health status is often the result of unfair, unacceptable and avoidable conditions, (related to gender, sex, age, rural/urban settings, education, wealth, ethnicity, migrant status, etc.) and true to its constitutional mandate to promote and ensure the "highest attainable standard of health as one of the fundamental rights of every human being," WHO has taken steps to ensure that cross-cutting values of gender equality, health equity and human rights standards and principles are applied more systematically across the organization, through each and every category network, and across HQ, regional and country offices.

To achieve this task and as part of the organizational reforms in 2012, the Director General combined the existing work streams on gender and human rights, together with a focus on equity and equality monitoring to establish the Gender, Equity and Rights mainstreaming team.

The Gender, Equity and Rights team works directly with technical units across the organization in three areas:

1. Providing guidance and tools for mainstreaming into technical programmes and institutional mechanisms, including:
   - Programme Budget ‘benchmarks’ for GER (see Annex 1)
   - Gender parity requirements
   - Guidance on engagement with human rights treaty body mechanisms on the right to health and gender equality

2. Providing technical support and tools to promote the disaggregation of data, data analysis and health inequality monitoring
   - Health inequality monitoring tools
   - UHC indicators on equity

3. Providing country support to promote the integration of equity, social determinants, gender and human rights in national health programmes (joint GER-SDH initiative)
   - Step-wise methodology for reviewing how national health programmes can better account for equity, social determinants, gender and human rights.
Key messages

- WHO has a given mandate and commitment to mainstream gender, equity and human rights across all workstreams. This mandate is derived from:
  - UN Charter (Article 1. ‘Encouraging respect for human rights’)
  - WHO Constitution (preamble ‘The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction race, religion, political belief, economic or social condition.’)
  - WHO 12th General Programme of Work
  - UN System Wide Action Plan on mainstreaming gender (UNSWAP)
  - UN Secretary General’s ‘Rights Up Front’ action plan
  - UN Common Understanding of a Human rights based approach

- All WHO programmes will contribute to meeting Gender, Equity and Rights mainstreaming targets, based on a set of 12 ‘essential criteria’ included in the 2016–17 Programme Budget. These criteria include:
  - Staff capacity building;
  - Data disaggregation;
  - Engagement with human rights treaty bodies;
  - Promotion of equitable participation in programming and decision making;
  - Analysis of underserved populations/ coverage gaps;
  - Impact analysis from a gender, equity and human rights perspective;
  - Actions/steps taken to address the above.

- A baseline picture of these criteria has been established for 2014, and progress will be monitored annually against these measures. Tools and resources to support WHO staff to implement the criteria above, can be found below in the ‘resources’ section.

- WHO Country offices have responsibility to ensure that gender, equity and human rights analysis and actions are reflected in the Country Cooperation Strategy (See “The Guide for the Formulation of the WHO Country Cooperation Strategy”).

- Under the UN Human rights system, WHO country offices can provide support to Member States to monitor implementation of UN Treaty Body mechanisms (such as the Committee on Economic Social and Cultural Rights, the CEDAW Committee or the Committee on the Convention for the
Rights of the Child), Universal Periodic Reviews to the Human Rights Council or to support implementation of recommendations promoting the right to health and or to provide country-specific information to treaty bodies for the preparation of their reports.

- Under the UN Secretary General’s ‘Rights Up Front’ initiative, all UN staff, acting with the Resident Coordinator and UN Country Team, have a responsibility to monitor and undertake human rights situation assessments, with a view to averting serious violations of international human rights and humanitarian law.

Resources

- GER criteria (See Annex 1)
- UN System Wide Action Plan on Gender mainstreaming (UNSWAP)
- Summary UN Secretary General’s Rights up Front initiative
- Guidance on Human Rights Treaty bodies
  [http://www.ohchr.org/EN/HRBodies/Pages/TreatyBodies.aspx](http://www.ohchr.org/EN/HRBodies/Pages/TreatyBodies.aspx)
- Health inequalities monitoring Handbook
  [http://apps.who.int/iris/bitstream/10665/85345/1/9789241548632_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/85345/1/9789241548632_eng.pdf?ua=1)
- E-core module on GER
  [http://www.light-media.co.uk/vxxjgrijijifie\GER_MASTER_22_Sept_2014_jh.zip](http://www.light-media.co.uk/vxxjgrijijifie\GER_MASTER_22_Sept_2014_jh.zip)
- UNSWAP Training module I know Gender
  [https://trainingcentre.unwomen.org/](https://trainingcentre.unwomen.org/)
- UN Common Understanding of a human rights based approach
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Food safety

Background

Food safety is a multisectoral and interdisciplinary activity in which the public health sector needs to work closely together with agriculture, trade and other sectors. Such an approach (One Health) is also beneficial to the effective control of zoonoses and antimicrobial resistance. Good coordination between WHO and FAO country offices is a key.

- Many WHO activities in food safety are delivered jointly with the Food and Agriculture Organization of the United Nations (FAO) and/or the World Organisation for Animal Health (OIE).
- WHO advocates for importance to be given to food safety in the international, regional and national public health agenda and supports the leadership of the health sector in food safety.

Key messages

- The FAO/WHO Codex Alimentarius Commission protects the health of consumers and ensures fair practices in the food trade by setting international food standards. It organises some 15-20 meetings every year in Switzerland (Geneva), in Italy (Rome) and in other countries. The invitation letter is sent from the joint FAO/WHO Codex secretariat located in Rome to 186 Codex Members. WHO country offices are invited to attend Codex meetings when the latter take place in their countries.
- The Codex Contact Point (CCP) of a country may be located in the ministry of health, or agriculture, or trade or in the national standardization board. CCPs notify WHO and FAO of the composition of the national delegation and often coordinate national positions on technical matters for discussion in Codex meetings.
- WHO is acting as the secretariat for the Codex Trust Fund (CTF) aiming at enhancing the participation of developing countries and countries in transition economy in Codex activities. WHO/HQ counts on country offices to facilitate the implementation of CTF.
- The International Food Safety Authorities Network (INFOSAN) is a global network run by WHO and FAO that assists Member States in managing food safety risks, including through rapid sharing of information during food safety emergencies. While the notification mechanisms under the International Health Regulations (IHR) cover food safety issues, INFOSAN complements IHR by allowing both formal and informal communication across governmental entities that go beyond the public health sector. Direct communication takes place between country Emergency Contact Points and the INFOSAN Secretariat in WHO.
- More than 180 Member States have notified their INFOSAN Emergency Contact Points (one per country) and INFOSAN Focal Points (may be more than one per country). WCOs can support ongoing country involvement in INFOSAN.
WHO also supports Member States through the networks of specialised laboratories in food safety and antimicrobial resistance and by providing national needs assessment tools, tools to quantify the national estimates of the burden of food borne diseases, advocacy and training materials, risk assessments on a variety of food hazards, amongst others.

The year 2015 features a series of international food safety events to mobilise the Member States attention to food safety (e.g. World Health Day, Milano Expo 2015).

Resources

- WHA63.3 on advancing food safety initiatives
  http://apps.who.int/gb/ebwha/pdf_files/WHA63/A63_R3-en.pdf?ua=1
- Recommendations 53-57 of the Framework for Action adopted by the Second International Conference on Nutrition
- List of national Codex Contact Points
  http://www.codexalimentarius.org/members-observers/members/en/
- Advancing food safety initiatives: strategic plan for food safety including foodborne zoonoses 2013-2022
  http://www.who.int/iris/bitstream/10665/101542/http://apps.who.int/iris/bitstream/10665/101542/1/9789241506281_eng.pdf?ua=1
- Food safety in WHO
  http://www.who.int/foodsafety/en/

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Part III
Administration and management
Strategic and operational planning, budgeting, and performance monitoring and assessment

Background

Driven by a focus on results, the WHO reform is geared towards keeping pace with the changes in the health landscape in order to continue fulfilling WHO’s mandate of achieving the highest attainable standard of health. For WHO to deliver better results, it needs to focus its work at the country, regional and global levels to deliver clearly defined results. Budget and financing should then be aligned to the priorities identified through a bottom-up process.

Applying the results-based management framework ensures that this focus on results are embraced throughout the Organization. WHO’s results-based management framework begins with setting the vision and strategic direction by the General Programme of Work (GPW). This is then articulated by the biennial Programme Budget and the operational plans, which are then subsequently financed and implemented. The full cycle is completed by the monitoring and evaluation to assess the achievement of results and applying these results to planning, implementation and continuous organizational learning.

All three levels of the Organization are engaged in all stages of results based management process. The country offices play a very crucial part in providing the focus for all these stages. The identification of priorities starts at the country level.

At the country level, WHO priorities, WHO’s comparative advantages, national health priorities and plans and joint plans with other partners converge. As a robust country cooperation strategy brings these together, it is important that CCS is seen as integral part of the results based management framework and that WHO programme budget and operational plans are strongly aligned to it.

Key messages

**Strategic planning**

The General Programme of Work (GPW) provides a high-level strategic vision for the work in the medium-term. The current 12th GPW defines the leadership priorities that give focus and direction to WHO’s work from 2014 through to end of 2019. The GPW has been influenced by extensive analysis of the country cooperation strategies and experiences feeding into its development.

- The country offices should engage in the strategic direction setting for health and cooperation at the country level, ensure that WHO is able to exert its influence in the national strategic and policy development processes in line with its vision, strategies and leadership priorities. At the same time, the country offices should articulate the needs in countries and national priorities in WHO’s strategic and planning processes, ensuring that the priorities, plans and budgets of WHO are in line with them.

- The country offices should engage all stakeholders that contribute to or influence the health sector so that support to the country is relevant, appropriate and in line with international norms and standards, evidence-based strategies and plans.
Programme Budget

The Programme Budget (PB) articulates the results to which the Organization contributes and for which it is accountable. The work and the budgets required to achieve them overall at each of the levels of the Organization are also determined. The WHO Constitution requires the Secretariat to present a Programme Budget for the entire Organization for approval by the World Health Assembly every two years.

The PB fulfils multiple functions. It is WHO’s primary tool for programming its work. It articulates the priority work across the three levels of the organization and the resources required. It provides the basis through which the work will be financed, as well as measure the performance and achievement of results. It also serves as a tool for resource mobilization.

- As the programme budget is geared towards achieving outcomes and impacts to the health of the people, the country offices must ensure that a robust process is in place for the identification of health needs and priorities for WHO technical cooperation at the country level.

- The country office should ensure that adequate consultations with country stakeholders are in place. The needs and priorities in countries should then inform the regional and global priorities which all converge in the programme budget.

- The countries offices should take into account ongoing and emerging priorities, including those commitments at regional and global levels that are confirmed by the programme area networks.

- The country offices should align the country office budget with the agreed priorities during the programme budget development process and align resource mobilization efforts at the country level with the programme budget.

Operational planning

The strategic vision of the GPW and the biennial direction of work and budgets are put into operation by the operational plans. During operational planning, budget centers set priority tasks, analyse options, identify partnerships, establish assumptions and assess risks to programme delivery.

Operational planning is carried out by every budget center, which is the basic unit for planning and implementation. A country office is usually a budget centre. The Head of the WHO Offices (HWO) is normally the head of the country budget centre and leads the operational planning for the country budget centre.

Operational planning is done prior to the start of the biennium. Beginning in the 2016-2017 biennium, the operational planning is being rolled out a year prior to the start of the biennium to institute rigour and longer consultation period in the development of the plans.

The outcome of the operational planning process is the completion of workplans, which define sets of products and services, and elaborates staff and activities, corresponding costs and budgets required to achieve them, timeframe of their delivery and risks and assumptions.

Operational planning is a crucial exercise in the process for aligning human resources and activities with the overall priorities of the organization and with the health needs and priorities at the country level.

- Every budget center and its staff across the Organization should be involved in operational planning.
Every budget center should adhere to guidelines and timelines set for planning overall at the global level, which are then supplemented by the regional level based on their specific context. The regions are responsible for determining the budget centre’s programme budget allocation that sets the initial expectations of the scale or boundaries for the staff and activity budgets.

Country budget centres should consult with regional office planning departments during the process. Technical officers should have discussions with the regional programme area networks focal points to ensure that the workplans are technical sound and consistent with the organizational strategy for the specific programme area.

How the operational planning process is carried out varies across country budget centres. In some countries, there are structured consultations with country counterparts where the operational plans are agreed with the Ministry of Health. Budget centre managers are expected to ensure that there is adequate consultation within the office and with the country counterparts.

Operational planning is not merely an exercise of listing staffing and activities in GSM. A rigorous process of determining what needs to be delivered by the budget center, the staffing and activities required in the biennium should be in place. Every staff in the budget center should be involved.

**Workplan**

In WHO’s Results-based Management Framework, workplans:

- are the expression of collective and individual accountabilities for results;
- indicate the agreed manner by which results are to be achieved within authorized resources; and
- provide a basis for monitoring and assessing the performance of teams and individual staff members.

A workplan is owned by only one budget centre, although a budget center can have multiple workplans. Workplans are developed for the whole biennium, although specific products and services (usually referred to as top task in GSM) may be achieved within a shorter period of time.

Workplans have two principal components: an activity workplan and a human resources workplan.

1. The activity workplan defines sets of top tasks with their associated activities (i.e., lower tasks) and costs, establishes time frames and assigns responsibilities for their implementation. Activities that are necessary to deliver a product or service must be identified.

2. Human resources plan component of the workplan provides details on the planned staff positions with details on the grade, reporting lines, outputs linked to it, duration, costs that are initially determined by a standard post cost-average for the position and duty station.
   - All workplans must be costed. Costing a workplan is the process of determining the estimated financial resources required (i.e. planned costs). Planned costs should be determined at the lower task level in GSM. Planned costs are revised to reflect the reality during implementation. The aggregate total of planned costs should not exceed the allocation for the budget center, by category.
• Budget centres cannot implement activities and spend WHO resources without an approved workplan. Therefore, budget centres should not commit the Organization to any contractual liability or initiate any work with contractors and partners without an approved workplan.

• Workplans cannot be approved without planned costs and before a thorough quality assurance. HWOs must ensure that the workplans are quality assured, i.e., adherence to SOPs, completeness, as well as adequacy to achieve results and relevance, appropriateness and efficiency of strategies it employs.

Performance monitoring and assessment

Performance monitoring refers to a continuous review of progress, while assessment is a periodic judgment about achievements. Performance monitoring can take place in the form of ad hoc reviews of progress in implementing workplans.

Monitoring is a continuous process whose main purpose is to review regularly implementation of workplans, assess and report on the accomplishment of tasks and the achievement of expected results at country, regional, Headquarters and Organization-wide levels. Monitoring also allows for the identification of areas of programme delivery requiring improvement or adjustment.

As a Secretariat, the Member States have mandated WHO to report on the progress in implementing the programme budget and report on the performance of WHO based on the results agreed in the programme budget. There are two mandatory reports that are presented to the governing bodies of WHO, these include:

• Mid-term review (MTR) - MTR focuses on the progress towards the achievement of the outputs, and the contribution of each organizational level of the Secretariat, in accordance with the planned deliverables in the programme budget. The purpose is to make midterm corrections to implementation and further inform planning for the current and future biennium. It is conducted at the end of the first year of the biennium.

• Programme Budget Performance Assessment (PBPA). The purpose is to assess the actual achievements of Organizational results, both in terms of results for which WHO is accountable and those to which it contribute, that are described in the programme budget. The analysis how WHO’s has contributed to the outcomes is also done and taking stock on the lessons learned for policy, planning and Organizational learning. This is undertaken at the end of the biennium.

There are several others means for monitoring, assessing performance and evaluating effectiveness and efficiency in terms of programmatic and managerial aspects initiated at all levels of the Organization and outside the Organization.

Monitoring and performance assessment is an integral part of the results based management cycle and is crucial for enabling an effective, efficient organization that is continuously learning.

• Every budget center must ensure that it is monitoring the implementation of its workplan, both in terms of financial and programmatic performance, and making sure that the results are analysed and used for improving accountability and performance at the country level.

• HWOs must ensure that workplan monitoring should be designed and managed in such a way as to allow for improvements in programme delivery on a regular basis.
• Country budget centres should make sure that country office inputs are meaningful and are provided in a timely manner for the regional and global processes.

• HWOs must ensure that there in an adequate and appropriate feedback at the country level to improve implementation, to be used for future planning and to communicate the results of the Organization.

Resources

› General Programme of Work 2014-2019

› Programme Budget 2014-2015
  http://who.int/about/resources_planning/PB14-15_en.pdf?ua=1

› Additional guidance notes for global processes are posted on the PRP intranet site
  http://intranet.who.int/homes/prp/

› Step-by-step guide in developing salary workplans in GSM are available, i.e., User Productivity Kit (UPK)
  http://intranet.who.int/tools/gsmupk/toc.html

Contacts

In regional offices, contact the DAFs and DPMs

In headquarters, contact:

• Sussan Bassiri, Director, PRP, (bassiris@who.int)
• Brian Elliot, Chief Budget, PRP (elliottb@who.int)
• Bernard Tomas, Senior Planning Officer, PRP (tomasb@who.int)
Financial management and accountability at country level: Imprest and bank account management

Background

Imprest accounts are established to provide adequate levels of funding available to Country Offices (CO) to facilitate timely and efficient implementation of programme activities for local low-value non-recurring payments. Imprest accounts are normally maintained in the local currency of the CO. Accounts in other currencies, such as US Dollars or Euros may also be allowed if required by the country’s banking and currency conditions.

There are two types of Imprest accounts: an Imprest bank account and an Imprest cash account. Funds in the Imprest bank account are held in a financial institution in the country of operation and Imprest cash accounts consist of cash on hand (i.e. petty cash) to meet small everyday expenses. Petty cash must be secured, normally in a safe or locked cash box, and kept at a minimum level. Imprest cash accounts are replenished through the local Imprest bank account. An Imprest cash account may only be used if a local Imprest bank account is available. However, an Imprest bank account may be used without the requirement for an Imprest cash account.

Regardless of whether it is an Imprest bank account or an Imprest cash account, separate disbursement records and month-end reconciliations must be maintained and performed for both accounts.

Key messages

Responsibility

Each Imprest account is under the responsibility of a nominated WHO staff member (the HWO or WR) who is responsible to ensure that there are no unauthorized disbursements, no misused or unaccounted funds, and to ensure that operations and reporting of the Imprest activities are in accordance with WHO’s Financial Regulations and Rules. Funds held in the Imprest bank accounts and Imprest cash accounts are under the personal responsibility of the Imprest holder and any unauthorized disbursement or misused or unaccounted funds may result in recovery from the Imprest holder.

The Imprest holder’s responsibilities include:

- Review, approve, and sign (as evidence of the WR’s review and approval) the monthly bank reconciliations and cash certificates.
- Sign all vouchers – this task can be delegated to another responsible staff member by the Imprest Holder.
- Review the payments and receipts list for the month and follow up on any unusual or unapproved transactions.
• Ensure a knowledgeable and authorized staff member manages Imprest on a daily basis (including the recording of all Imprest transactions the day they occur) and that he or she completes the monthly reconciliations on time and accurately (completed Imprest returns are due to be sent to the controlling office by the 10th day of the following month).

Authority
An Imprest account may be opened following authorization from the Regional Director (RD) for regionally controlled accounts and by the Chief Finance for HQ accounts. Similarly, administrative changes to Imprest accounts, such as opening and closing the account, updating signatory panels etc., are only permitted with the approval of the RD (for regionally controlled accounts) or Chief Finance (for HQ accounts) in line with the relevant delegation of authority. Treasury facilitates the performance of these actions by ensuring that the accounts are properly set up in GSM.

Imprest Ceiling Levels/Replenishments
• The level of an Imprest bank account (i.e. the ceiling) is determined by the Chief Finance for HQ controlled accounts and by the regional Director of Administration and Finance (DAF) for regionally controlled accounts. The ceiling of the Imprest bank account is established at a minimum amount which will be sufficient for satisfactory programme operation, local payments and payments on behalf of the Global Service Center. Further guidance on the establishment of the ceiling level is provided in WHO’s eManual X.3 Imprest.
• In order to maintain the Imprest bank account at the established ceiling, replenishment of the Imprest bank account is normally done at the beginning of each month, however, country offices may request an “ad hoc” replenishment to cover exceptional levels of disbursements for a specific period.

Oversight and monitoring
• Ensure that the bank panel of signatories has been updated to reflect the name of the new HWO (document to be provided by the Administrative Officer or the Operation officer).
• Make sure that the bank balance according to the statement from the bank corresponds to eImprest bank account in GSM at the handover point.
• Ensure that the new eImprest holder name (HWO) is correctly recorded in eImprest/GSM (Treasury will update the information in GSM based on instruction from the CO).
• Ensure that a staff member (typically the local Administrative Officer), with sufficient knowledge and appropriate training, is assigned to manage eImprest and complete the bank reconciliations each month.

Imprest payments
• Payments using Imprest should only be made against the following financial documents:
  - Imprest Purchase Orders (IPOs),
  - Payment instructions received from Accounts Payable/GSC.
• At the beginning of each year or biennium, one or more IPOs should be created to cover the operational costs for the office. These costs are paid through the eImprest account. The IPO(s) should be set up for general operating expenses only and should not exceed US$ 50 000 per IPO. Each IPO should preferably be raised for a unique PTAEO.

• Transactions charged to IPOs should not exceed US$ 2500 per transaction with the exception of SSA salaries and Direct Implementation activities, where transactions may exceed this limit.

• An IPO should be raised for a period of six months to one year however, the IPO must always be closed by the award end date.

• The IPO must be linked to a valid PTAEO (budget and accounting charge coding) and full support must be attached.

• IPOs are also used for implementing Direct Implementation (DI) activities which are discussed in the DI section of this handbook.

**Required supporting documents**

**Monthly Bank Reconciliations**

• Bank Statement
• WHO Form 412
• WHO Form 413
• Outstanding Items Report
• Supporting documents such as voucher and receipt details

The Bank reconciliation is the fundamental control for ensuring the complete and correct recording of all transactions during the month, and that the accounting agrees with the cash and bank transactions. When reviewing the Monthly Returns, it is important to look into all large transactions, that totals agree and that any differences include an explanation, before signing off the returns.

Experience shows that some frauds could have been prevented if thorough review had taken place prior to signing off bank reconciliations.

**Payment Vouchers**

• Original invoice(s)
• Journal Voucher (including signature of approval)
• Any other supporting documentation as appropriate

It is the responsibility of the Head of WHO Office/ WR as the Imprest holder to sign all the required documents. However, the signing off / authorizing of payment vouchers, journal vouchers and other supporting documentation under point (2) above may be delegated to another responsible person in the office (such as an Administrative / Operations Officer). The monthly returns, however (items under point (1) above) must always be signed by the Imprest holder him/ herself, except in case of absence when the person acting temporarily for the Imprest holder may sign these on his/ her behalf.
Allowable expenditures in eImprest

- Payments against IPOs should only be made against an original invoice and in accordance with the purpose for which the commitment was established.
- Only small, non-recurring transactions should be processed through IPOs.
- Any requests for payment without an IPO/ Payment Instruction from GSC should not be processed.
- Regular and recurring transactions such as office rent should be processed using the regular procure-to-pay cycle through GSC.
- Staff and other personnel costs (salary, medical reimbursements, etc.) should not be paid through eImprest unless a specific Payment Instruction has been received from GSC.
- All payments (travel advances, salary payments, etc.) initiated by GSC (accounts payable) should be done through eImprest upon receipt by the eImprest holder of the payment instructions from GSC.
- Travel advances for staff member holding a Travel Request should not be processed without a payment instruction from GSC.
- No salary advance should be paid without a payment instruction from GSC.
- No APWs, Contractual Service or Technical Service Agreement can be paid through an eImprest without a payment instruction from GSC.

Routine financial management

- Always ensure that there is proper background/justification for any payment before authorizing the payment and signing the journal voucher.
- Make sure the amount quoted on the cheque issued is the same as the invoice submitted and the amount recorded in GSM, and that supporting documents are attached.
- Avoid cash payments, unless absolutely necessary.
- Avoid using eImprest unless direct payment through GSC is not possible.
- Conduct random checks of transactions exceeding US$2500.
- Avoid authorizing or approving any advance payments.
- Do not authorize any payment without an IPO or Payment Instruction from GSC.
- Ensure all financial documents submitted before the end of the month have been signed.
- Make sure that the Imprest reconciliation is always performed on a monthly basis (and preferably weekly) to ensure any issues are identified on a timely basis.
- Review and approve the monthly bank reconciliation. Sign the statement of account, if the cash book and the bank statement tally.
• In case of a difference between the bank statement and the cash book, an explanation must be given by the Administrative Officer or the Administrative assistant. Ensure that this discrepancy is resolved on a timely basis by the Administrative Officer/Assistant.

• Ensure the Imprest reconciliation review checklist that is sent to the Regional Office is completed, together with all attachments (Bank statement, cash-book, certificate of cash account, and justification of outstanding checks).

• Do not accept bank reconciliations with negative balances (Cash-book or bank statement). If balances are negative, appropriate action should be taken.

• Transactions processed through eImprest should be minimal. Payments made through eImprest should be for small valued items and daily operational costs. eImprest should not be used in lieu of the regular procure-to-pay cycle unless payment via this process is not possible or cost-efficient.

Resources

› eManual – Imprest X.3:
  http://emanual.who.int/p10/s03/Pages/default.aspx

› eImprest Solution (elm prest) 1.0 User Guide:

› Petty Cash Manual:

› SOP Library in eManual
  FIN.SOP.X.001_elmprest_Creation_of_Accounts
  FIN.SOP.X.002_elmprest_Final_Closing_of_Account
  FIN.SOP.X.003_elmprest_New_User_Access
  FIN.SOP.X.004_elmprest_Bank_and_Cash_Reconciliations

Contacts

• Regional Office: Budget and Finance Officer (BFO) and the Director of Administration and Finance (DAF)

• Headquarters: Expenditure Analysis and Control (FNM/ACT)

• Global Service Centre: gsd@who.int; GPN: 17000
Financial management and accountability at the country level: Award management

**Background**

An award is a contribution to support an activity or set of activities that commences with confirmed funding (normally a signed donor agreement) and ends when the award is reported and the objectives are accomplished according to the agreed, pre-defined responsibilities, within the given timeframe, resources and budget. An award funds one or more workplans. All revenue and expenditure is recorded against an award. Awards form the ‘A’ in the PTAEO (Project, Task, Award, Expenditure, Organization) which must be cited when encumbering funds and incurring expenditure. Awards are established for in-cash contributions as well as in-kind and in-service donations.

Award management is a core responsibility of managers who have access to donor funds. Ensuring that voluntary contributions are utilized in accordance with signed donor agreements, fully implemented as agreed, and that reports to donors are accurate and delivered on a timely basis are key to ensuring donor confidence in the Organization and in upholding WHO’s reputation. Good award management is a prerequisite to ensuring future voluntary funding for the Organization.

**Key messages**

**Award Manager Responsibility**

The Award Manager (AM) has overall managerial responsibility and authority for establishing and administering the award in accordance with the conditions of the donor agreement. This specifically includes initiating the award creation in GSM, designating how the award should be spent (distribution), monitoring the technical and financial implementation, as well as reporting back to the donor. The AM is also responsible for following up any amounts due from the donor (amounts receivable). Regular summaries on amounts receivable, undistributed funds, expiring awards, reports due to donors as well as other information on awards, are shared by the Awards unit and posted on the following site – [http://intranet.who.int/homes/act/awa](http://intranet.who.int/homes/act/awa).

**Authority**

Each award is assigned to an AM who is accountable for the award throughout the award’s lifecycle until closure. The AM may name a staff member as Award Administrator to assist in the administration of the award however this is not mandatory.

**Award Cycle**

The steps in the award cycle in the diagram below are followed after having successfully concluded an agreement for voluntary funding of WHO’s work. For step 1: Donor Agreement clearance, refer to the document PRP.SOP.IV.001 Donor Agreement End to End. Steps 2 – 7 are described in detail in the document FIN.SOP.IV.010 Award End to End.
1. **Donor agreement clearance** – please refer to SOP Donor Agreement End to End.

2. **Activate Award**: The signing of an agreement triggers the activation of a new award. A new award is activated in GSM by submitting an Award Activation Request (AAR) to awards@who.int. There is no need to wait until cash is received to create an award – awards can be opened based on a counter-signed agreement.

3. **Distribute Award**: Award distribution is the internal management decision identifying which Category, Major Office (MO) and Budget Centre (BC) should participate in the implementation of the award and how much of the award is assigned to the BC to carry out the activities. The distribution must be in line with the terms and conditions of the agreement. The distribution can be included on the AAR form or requested by submitting an Award Distribution Request (ADR) form. Award Managers must ensure timely distribution of the awards under their management to ensure full and timely implementation of the project.

4. **Fund projects** (workplan funding): Once the award distribution has been entered to the BC level, funding can be requested to any of the Projects (workplans) of that BC. Workplan funding requests are submitted through the GSM and approved by the Project Manager of that BC.

5. **Award Budget** (funding top tasks in the workplan): In order for the funds to be available for implementation, the Project Manager must apply the funds to the appropriate top task in the workplan. This is called the ‘award budget’. The award budget must be in line with the distribution by Category and programme area. Once the Project Manager (workplan manager) has approved the award budget in GSM, resources are available for implementation and this Project, Task, Award (PTA) combination can be indicated when creating an encumbrance.

6. **Implement, Manage, Monitor**: Once funds are award budgeted, implementation can commence. Implementation includes creating encumbrances such as entering purchase requisitions for goods and services (e.g. APWs), travel requests as well as mapping and funding staff to the award.

7. **Close Award**: All awards must have an end date and a close date. The END DATE is the date by which activities should be completed, per to donor agreement. The CLOSE DATE is typically 6-12 months after the end date, during which time outstanding encumbrances should be liquidated and final payments made. No new activities can be initiated after the end date as GSM will not allow encumbrances after that date. No payments or further activity can occur after the close date, and all open encumbrances must be cancelled.

   Before the END DATE, the award manager should review all existing encumbrances, cancel any that are no longer valid and make sure that all the rest are fully liquidated before the award CLOSE DATE.

   The award manager must ensure that final reports to the donor are submitted on a timely basis and request awards unit to refund any final remaining funds to the donor as required.
**Overall key messages**

- Ensure full cost recovery, appropriate PSC rate, detailed budget and appropriate clearance when negotiating a donor agreement
- Ensure timely distribution, workplan funding and award budgets for all available funds
- Implementation and reporting must be in line with donor agreements
- Regular monitoring of implementation of awards and workplans including encumbrances is important.
- Key dates:
  - **Start date**: should be indicated in the donor agreement. This is the date the award is opened and implementation of the agreed activities should start.
  - **End date**: This should also be indicated in the donor agreement. This is the date by which all products and services funded from the award are due to be completed and delivered. In GSM, no new encumbrances can be entered after the end date.
  - **Close date**: The close date should be indicated in the donor agreement. This is the date after which no further transactions can be recorded. All encumbrances must be cleared and final payments made before the close date.

Donor reporting: all requirements to report back to the donor must be clearly indicated in the donor agreement. Information on the types of reports due, the dates of donor reporting and the status of donor reporting is entered in GSM and is available either on screen or through reports. This enables the Award Manager and others to monitor and follow up the outstanding reports.

**Resources**

- eManual section
  - IV.3 Award Creation and Management
    - [http://intranet.who.int/homes/act/awards](http://intranet.who.int/homes/act/awards)
- SOP Library in eManual
  - [http://emanual.who.int/eM_RelCont_Lib/Forms/SOPs.aspx](http://emanual.who.int/eM_RelCont_Lib/Forms/SOPs.aspx)
- FIN.SOP.IV.010 Award End to End
- PRP.SOP.IV.001 Donor Agreement End to End

**Contacts**

- **Regional Office**: Director of Administration and Finance (DAF) and the Budget and Finance Office (BFO)
- **Headquarters**: Accounts (FNM/ACT); GSC: Awards unit
- **Global Service Centre**: [gsd@who.int](mailto:gsd@who.int); GPN: 17000
Financial management and accountability at the country level: Direct Financial Cooperation (DFC)

Background

Direct Financial Cooperation (DFC) are payments made to the governments of Member States to cover costs of items or activities that would otherwise be borne by the governments themselves, in order to strengthen their health development capacity and ability to participate more effectively in, or to meet their commitments to, WHO technical cooperation at country level.

DFCs make up a large portion of the implementation at country level in certain countries; at the same time, this is a high-risk area due to the fact that WHO does not have control over the funds once they are disbursed to the governments and expensed. It is important that policy is followed diligently by programme managers and WRs when using DFC as a means of implementation at country level: DFC is a good and flexible capacity-building tool but this has to be balanced with its inherent risk due to lack of WHO control after disbursing the funds.

Key messages

Authority

DFC contributes directly to the achievement of WHO’s programme of work.

DFC-funded activities are subject to the same standards of accountability and evaluation in terms of relevance, efficiency, effectiveness and impact as any WHO technical cooperation programme, project or activity at country level.

The project leader or the WR has the responsibility for ensuring the timely implementation of the agreed activities and timely submission of acceptable post-activity reports and for verifying that:

- The planned activity, service or function has been performed in conformity with the programme objective indicated in the agreement and
- That the project expenditure reported reflects a fair accounting of disbursement of the concerned DFC funds.

Overall key messages

Non-emergency DFC activities should be planned at the beginning of each year, in line with the outputs agreed and elaborated in the PB for the biennium.

DFCs should be used only where it is not possible to use other mechanisms, e.g.:

- If WHO commissions work to other entities for specific deliverables, an APW should be used.
- If a large training is being planned, an APW could be used to contract an event management company to conduct it.
If e.g. vehicles are to be purchased, a goods PO should be raised instead of a DFC.

Regions and Countries should be selective in the use of DFC and only support countries that lack resources for implementation of health development activities.

Government counterparts need to be made aware of the reporting requirements of DFCs. The final deliverable is the 'DFC report' which has two parts: 1) a technical report whose level of detail is commensurate with the value of the DFC contract, and 2) financial certification on the 'FACE' form, including a detailed expenditure breakdown following the original approved budget. The DFC report is due within three months of completion of the activity.

There should be strictly no further DFC funding made available to recipients who have overdue reports on DFCs already provided to them. Outstanding DFC reports should be monitored carefully and regularly communicated to the counterparty.

When possible, DFCs should be paid in instalments, not 100% up front. Instalments should be linked to deliverables. The last instalment should be linked to the submission of the DFC report.

DFC agreements are formal agreements that are linked to an approved workplan for a WHO activity. A signed agreement must be in place before committing any funds. The agreement must:

- Show the relationship of the activity to the national health plan, health development or County Cooperation Strategy
- Include a budget with a breakdown of expenditure categories in sufficient detail.
- The cost estimates included in the budget should be reviewed for reasonableness by the responsible WHO officer and cleared by an administrative officer before approval.
- The DFC agreements must be in compliance with the donor agreement of the funding award.

Risk assessment of recipients should be performed by COs/ ROs. WR together with Regional BFOs and HQ assess the risks associated with cash transfers based on relevant criteria, e.g.:

- the amount of funding for the activity;
- overall DFC funding for the recipient in this period (year/ biennium);
- the recipient’s history of reporting;
- assessment of recipient’s financial management and accountability systems

As per the WHO policy on DFC, risk/ assurance activities should include:

- On-site monitoring and spot-checks of activities (these should be strengthened and expanded beyond the scope exercised today)
- Examination of supporting documentation and accounting entries when deemed necessary in the books of the governmental agency which is party to the agreement.
- Audit by WHO — the relevant portion of the government’s audited financial statements must also be made available upon request.
Resources

- eManual XVI.2 Direct Financial Cooperation
- SOP Library in eManual
  FIN.SOP.XVI.001 Direct Financial Cooperation
- PRT.SOP.VI.055 Services Requisition
- Related eManual section

Contacts

- **Regional Office:** Budget and Finance Officer (BFO) and Director of Administration and Finance (DAF)
- **Headquarters:** Accounts (FNM/ACT)
- **Global Service Centre:** gsd@who.int; GPN: 17000
Procurement

Background

Procurement of goods and services comprise the second largest expense category after staff costs. Non-observance of WHO procurement guidelines has been pointed out by the External Auditor in their previous reports. Also, some donors (e.g. EC) have expressed their concern on risks associated with procurement and emphasized WHO’s need to enhance control. Procurement is thus an area of critical managerial importance for all HWOs. Therefore, it is strongly recommended that HWOs establish and/or enhance an effective control mechanism to ensure country office procurement activities comply with the WHO procurement rules and regulations.

Key messages

Overview

• Follow – and ensure the entire country office team follows – the subsequent procurement principles:
  - Best value for money;
  - Effective competition;
  - Fairness, integrity and transparency; and
  - The best interest of WHO.

• Lead and ensure active HWO involvement in procurement activities, to mitigate risk. Procurement represents a reputational, financial, operational, fraud and administrative risk that has been repeatedly identified by auditors.

• Ensure responsibility and accountability among the relevant staff, for compliance with WHO’s procurement principles, rules and regulations in the Organization’s best interest, when it comes to purchasing goods and services. Country offices are responsible for local procurement of goods, and services/activities.

• Review documents for high value Purchase Orders (POs), but also be aware that low value purchases can be high risk area too, since 95% of all services POs are under the value of US$ 25,000 each. Compliant and well-documented procurement requests are key to minimizing risks, delays and the transaction costs of procurement.

• Review follow-up technical reports specifically related to services contracts during and/or after completion, e.g. Direct Financial Cooperation (DFC) report, technical and financial report for Technical Services Agreement (TSA), Agreement for Performance of Work (APW), Consultants. Procurement is not a one-off event.

• Be familiar with the roles and responsibilities of Global Procurement and Logistics (GPL):
  - GPL takes ownership of policy making for procurement related rules and regulations; changes/waiver of procurement rules and regulations should be referred to Coordinator of GPL for consultation.
GPL Global contract and procurement unit (GPL-GCP) is responsible for global procurement of goods and goods catalogue management.

GPL Processing unit (Goods processing team and Services processing team) ensures the administration of the purchasing transaction and submission of the Purchase Requisition in GSM, meeting the standard of validation, as per the list for procurement of services and procurement of goods below.

GPL processes the respective Goods Purchase Order (PO)/Services contract, distribution of global PO/contract, obtain acknowledgement of signed PO/contract, shipment arrangement and follow through, PO revision/cancellation/closure and providing training support to Regions and Country offices.

- To achieve the best value for money, strengthen the bidding procedure and selection process to have effective competition for all purchase activities regardless of value, and ensure this is documented in the Adjudication Report (AR). When the transaction exceeds the stipulated threshold, submit the evaluation and recommendation to the Contract Review Committee (CRC) for approval. Forward all waiver of competitive bidding for value US$ 25 000 or above to DAF/CRC for approval.

- Discourage retroactivity due to urgent unplanned purchases because it exposes WHO to loss of opportunity in securing best value for money. Where retroactivity is unavoidable, prepare a retroactive justification memo and submit to the DAF for exceptional approval.

- Comply with policy, rules and regulations to safeguard WHO’s best interests. Be familiar with these policies, rules and regulations (as per the attached policy, rules and regulations).

- Initiate/maintain staff training and internal control mechanism, in order to improve quality of purchasing transactions, which directly improves process efficiency and accountability.

- Address reputational risk due to audit observation, with close observations and compliance to procurement principles.

- Ensure proper budgeting and planning so that procurement processes are conducted in adequate time.

- Ensure supporting documents are stored and archived in the Record Management System (RMS) for retrieval and audit purposes; and ensure appropriate use of the system by CO staff members without violation of confidentiality.

**Policy, rules and regulations**

HWOs should ensure:

- Transparency through better segregation of duty to avoid conflict of interest and improve the internal control framework;

- Sub-delegation of authority has been clearly defined in consideration of segregation of duty (e.g. adjudication report should not be prepared and approved within the same unit, waiver authority should not be sub-delegated to Compliance unit, etc.);

- Abuse/misuse of Goods PO types and Services Contract types has been controlled to ensure no intentional breach;
• Waiver of competitive bidding, sole supplier for new purchase, recurrence or renewal have been minimised;
• Pre-payment is only used if absolutely necessary and justifiable;
• Retroactivity due to urgent unplanned purchases is minimized so that WHO does not use the opportunity to secure best value for money. If unavoidable, prepare a retroactive justification memo to submit for the DAF’s exceptional approval;
• Adherence to consultant pay band rate and standard recruitment process;
• Better monitoring of timely submission and quality of Direct Financial Cooperation (DFC) technical and financial reports from Government.

**Goods procurement**

Once a formal request is received from Programme Manager/MOH/nodal ministry, the country office, with oversight from the HWO, needs to:

• Ensure availability of funding and that items requested are in line with the work plan;
• Verify that specifications for the list of items have been provided (quantity; catalogue numbers; supplier reference; power specifications for equipment; installation requirements; order of priority of listed items).
• Check that the expected delivery date allows sufficient lead time
• Identify the preferred mode of shipment.
• Check whether the items are available locally, and estimated costing. (If the items are not available locally, if the cost exceeds the HWO’s delegation of authority, or if it is more beneficial to procure from global sources, submit the request to the RO for action).
• Ensure that necessary technical/budgetary clearances and advice have been obtained from regional office before processing the request.
• Verify that future procurement requests are consolidated to obtain economies of scale.
• Check that other requirements such as spares, warranty, after sales service, installation, training, buy back, updates, import/export permit, embargo, special markings, green product, country of origin requirement, offsite/onsite support, turn-around time etc. have been specified.
• Ensure justification has been provided with the request for a sole source or proprietary item.
• Check that a Request for Price Estimate (RPE) has been created in GSM as well as a Records Management System (RMS) folder, and that all relevant documents and links have been uploaded before submitting. Note: a RMS folder needs to be created for each procurement requisition even if there is no attachment.
• Verify that selection and bidding processes are transparent and in line with WHO procurement rules and policy, where items are available locally.
• Ensure that the receipt is entered in GSM upon delivery of goods to the end-users enabling payment to the supplier.
• In case of reimbursable procurement, assess the need and whether to accept the request in principle. Consult the RO/BFO if MOH wants to deposit the money in local currency.

Issues to know for the procurement of goods:

With regards to the following, HWOs should provide oversight to ensure:

• The CRC number is updated in the GSM Purchase Order (for POs ≥ US$ 200 000)
• A justification code is updated in the GSM Purchase Order (for Non Catalogue POs US$ 25 000 to < CRC Threshold Value).
• The existence of CRC memo in RMS and CRC submission number is updated in the GSM Purchase Order (for Non Catalogue POs ≥ CRC Threshold Value)
• Accurate incoterm and mode of shipment provided for specific freight arrangement
• Accurate mandatory shipment information such as cold chain requirement, green light, embargo are flagged to relevant parties.
• Freight quotes are sought from the forwarder
• Accurate shipping and consignee address
• Justification has been provided for retroactive requests

Services Procurement

The country office, with oversight from the HWOs, needs to:

• Ascertain the needs of services contract;
• Finalize the Terms of Reference (TOR);
• Conduct the selection process in compliance with procurement rules;
• Compile a technical and commercial evaluation;
• Prepare the necessary recommendation of award and approval, documents to obtain approval from appropriate authorities;
• Obtaining the allocated budget (PTAEO) to fund the purchase;
• Archive related documents in the RMS;
• Register new suppliers in GSM;
• Submit a Purchase Requisition in GSM with complete documents;
• Follow through workplan approval in GSM;
• Distribute local contract to supplier;
• Monitor project delivery and progress;
• Follow-up for technical progress report or financial report from supplier;
• Act as receiver to ensure satisfactory completion of delivery before entering Receipt in GSM to approve and initiate payment process;
• Submit supplier’s invoice to accountspayable@who.int;
• Act as liaison officer between WHO and supplier.
Issues to know of procurement services

HWOs should provide oversight to ensure:

- The mandatory supporting documents are attached with the submitted requests:
  - An Adjudication Report: for any Contracts Value up to Contract Review Committee (CRC) Threshold Value;
  - CRC memo: ≥ CRC Threshold Value;
  - Waiver of bidding process or Sole supplier justification memo.
- The contracting partner in the Adjudication Report or the selection memorandum matches with registration page
- The Adjudication Report or the selection memorandum is signed
- The bidding process stated in the Adjudication Report.
- CRC memo is cleared by the CRC panel
- The waiver or sole supplier is approved by HQ/regional CRC/DAF
- Mandatory deliverables are provided or stated clearly
- Payment structure is followed which includes justification of pre-payment
- Approval is provided for Retroactive requests
- Ensure the existence of mandatory information such as Contractual Partner, TOR, Registry files for specific contracts

Resources

Participants were also referred to a number of key resources:

- Questions and answers related to procurement: 
  http://intranet.who.int/homes/ccu/documents/procurement%20questions%20and%20answers.docx
- Sections VI and XVI (for TSA, DFC, LOA, and Fellowship)
- Services Guidance Notes: 
  http://workspace.who.int/sites/whogsc/Publ_Docs/20200_ProcurementServicesGuidanceNotes.pdf
- Procurement Discrepancies FAQs: 
  http://workspace.who.int/sites/whogsc/Publ_Docs/20200_ServiceProcurementDiscrepancies_FAQ_English.pdf
- Audit Reports: http://intranet.who.int/homes/fpg/o/
- Intranet – GSC/Procurement Services: 
  http://intranet.who.int/homes/gsc/gscservices/procurementservices/
## Contacts

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<tr>
<th>Region</th>
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<tr>
<td>RO</td>
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<td><a href="mailto:ogitam@who.int">ogitam@who.int</a></td>
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</table>
| GSC    | Director: Francisco E.V. Cardenas  
  Coordinator: Motohiro Ogita | cardenasf@who.int      |
|        | Comptroller: Nick Jeffreys | jeffreysn@who.int      |
Compliance, risk management and ethics

Background
The mandate of the Department of Compliance, Risk Management and Ethics (CRE) is to:

- Identify organization-wide risks, maintain a risk register record, evaluate it according to its likely impact and probability and proactively have it managed by risk management owners.
- Periodically review, assess and integrate internal control compliance into all policies and management decisions.
- Promote and uphold the highest organizational standards, ethical codes of conduct and core values.

Key messages

Risk Management

- **Risk Management Framework/Policy**: currently being developed by the Compliance and Risk Management Team.
- **Risk Register**: an Organization-wide template has been developed and rolled out across all three levels of the Organization. The objective is to allow Budget Centres to identify the risks they face, and to propose mitigation strategies to manage them proactively. The risk register will be updated on a six monthly basis and an escalation mechanism put in place.
- **Risk Management Training**: Training tools have been developed to support Budget Centres in collaboration with SDLS.
- **Risk reporting**: annually to WHO’s governing bodies.

Effective risk management is a cyclical and iterative process, using monitoring as a feedback loop.

Compliance

- **Compliance Advice**: regarding business processes, best practices and suggesting process changes to increase operation efficiency and control, and improve overall effectiveness.
- **Performance Measurement/Assessment Tools**: under development and soon to be disseminated to the regions and country offices.

Compliance is a dynamic process serving as a mitigating factor and subject to regular reviews.

Ethics

- **Code of Ethics**: currently under development, it will be disseminated in HQ, Regional (except PAHO) and Country Offices.
- **Ethics Training**: to be developed. It will be implemented throughout HQ, Regional (except PAHO) and Country Offices.
• Declaration of Interests: of staff members and external individual experts. CRE provides advice on conflicts of interest to relevant technical units/departments.

• Protection Against Sexual Abuse and Exploitation policy: currently under development.

• Ethics Advice: Provision of advice and guidance to staff members dealing with various issues. On a strictly confidential basis.

• Ethics Advice Policy: Provision of ethics advice to business owners in policy development.

• Whistleblowing and protection against retaliation policy: under review. The updated policy will be disseminated across the Organization soon.

Resources
Intranet site - http://intranet.who.int/homes/cre/

Contacts
All CRE contact details are available on the departmental intranet site.
Internal oversight

Background

The Office of Internal Oversight Services (IOS) provides independent and objective assurance and advisory services, designed to add value to and improve the Organization’s operations. IOS helps the Organization accomplish its objectives by evaluating and improving the effectiveness of processes for risk management, control and governance.

The audit functions performed by IOS contribute to enhancing the operational effectiveness of WHO in countries, territories and areas. The main purpose of internal audits is to help improve country office operations, by identifying areas of weaknesses in internal controls and non-compliance with WHO rules, and making recommendations for improvement. IOS also raises concerns with recurring or systemic issues with the appropriate levels of management.

Key messages

- In line with the delegation of authority from the DG and RDs, HWOs are responsible for risk management, control and governance over country activities and audits are one mechanism to provide assurance that internal controls are in-place and operating effectively.

- Audit recommendations are focused on addressing the most critical areas, i.e. high significance and low effort, and they are discussed with the country office during the reporting process to ensure they are practical and implementable.

- While all recommendations are followed-up and monitored until closed, those that are of high criticality/significance but relatively easy to do, are expected to be implemented within six months from the issuance of the audit report.

- Audits are also performed “remotely” based on desk reviews using information in GSM and the RMS systems or in the form of integrated audits, combining assessments of both operational and programmatic areas, focusing on the performance of “WHO delivering in countries”.

- To avoid some of the common potential pitfalls related to country office management that are identified by audits, HWOs should:
  1. Use common sense to assess the risks that might arise in relation to a particular decision in terms of thinking about “what could go wrong” and for each issue identified, consider what practical steps could be taken to prevent or minimize these risks to an acceptable level;
  2. Document the decisions supporting what things are done and why;
  3. Don’t be afraid to ask for help when needed; and
  4. Think of yourself as a manager, in addition to being a technical expert.
  5. Always think before you sign!
  6. If there are any suspected irregularities that warrant consideration, contact confidentially the Office of Investigations at investigation@who.int.
Resources

- IOS intranet site: [http://intranet.who.int/homes/ios/](http://intranet.who.int/homes/ios/)
- IOS reports to the WHA, which highlight findings from country office audits as well as many of the recurring issues identified in past audits:

Contacts

**Headquarters**: David Webb ([webbd@who.int](mailto:webbd@who.int)) and Deepak Thapa ([thapad@who.int](mailto:thapad@who.int))
Legal matters

Background

The Office of the Legal Counsel (LEG) handles legal issues arising at headquarters, regional offices (except PAHO, which has its own Legal Office), and country offices. It is led by the Legal Counsel, and is part of the Director-General’s office. It provides legal advice, services and support, during the planning, decision and implementation of the Organization’s policies and activities; helps to ensure the integrity of policies and activities, and that the Organization acts consistently with its overall policy and rules. LEG’s overriding mission is to ensure that the Organization’s activities are carried out in accordance with its Constitution and the other statutory texts of the Organization.

Through Director Administration and Finance (DAF), HWOs are invited to consult the Office of the Legal Counsel (LEG) on issues related to privileges and immunities (P&I), and commercial and contractual matters (CCM).

Key messages

Privileges and immunities (P&I)

- Ensure that P&I are respected by the host country authorities and are not abused by staff members.
- If P&I incident occurs: Report the incident to DAF for appropriate action and clear all official communications (Notes Verbales) with DAF and LEG.
- Arrest and detention of staff: Immediately contact the Field Security Officer (FSO) & DAF and follow the procedure in WHO eManual.
- Legal notices and summons: Never accept if not transmitted by the Ministry of Foreign Affairs (MoFA). If no choice to refuse, write on receipt “without prejudice to WHO’s privileges and immunities”.
- Traffic accident involving WHO staff and/or WHO vehicle: Immediately Contact the FSO and DAF and report immediately to local insurance.
- Access to premises, documents, archives by local authorities: Refuse access and consult LEG through DAF.
- P&I incidents relating to taxes and customs affecting all UN system organizations in the host country: Contact the UN Resident Coordinator and then send background to LEG through DAF.
- Reporting to Police, filing of criminal complaint: Save in exceptional circumstances, do not involve national authorities before consulting LEG through DAF.
- WHO buildings and vehicles: Ensure that all are properly insured.
- All incidents: keep DAF and WHO/UN security officers informed. For issues relating to staff members, also keep the Regional Personal Officer (RPO) informed.
Commercial and contractual matters

LEG/Commercial and Contractual Matters (CCM) should be Consulted with regard to the following matters:

- Agreements (except for standard form agreements without any amendment)
- Amendments to agreements
- Organizational conflicts of interest
- Conflict of interest of experts
- Use of the WHO name and emblem with commercial implications
- Co-sponsorship of meetings with commercial implications
- Disputes
- CCM clearance of contracts and agreements: Clearance of (unmodified) standard WHO contracts is not required. All other types of agreements, including standard form agreements with amendments (APW, TSA, purchase order, consultants contract, the standard WHO donor agreement, etc.) and all non-standard contracts should be sent to LEG/CCM through DAF. Consult LEG/CCM before you modify existing agreements or draft new ones.
- Never sign a contractual document Giving jurisdiction to a national court. Use the standard applicable law and arbitration clauses provided by LEG as well as the standard clause on privileges and immunities.

When and how to consult LEG/CCM:

- Send a request for advice to DAF, who will contact LEG/CCM as required.
- Provide all relevant background information, including correspondence with the contractual partner, and the general background to the project.
- CCM should be consulted as early as possible.

Resources

Refer to the LEG intranet site for specific issues, as it provides a full list of guidance resources, as well as request forms, terms of reference and links to other relevant pages. http://intranet.who.int/homes/leg/

- List of responsibilities assigned to the International and Administrative Law (IAL) unit, on LEG’s intranet site:
  http://intranet.who.int/homes/leg/ial2/
- List of responsibilities assigned to the Commercial and Contractual Matters unit on LEG’s intranet site:
  http://intranet.who.int/homes/leg/ccm/
- PowerPoint Presentations – “Privileges and immunities; commercial and contractual matters”
  http://intranet.who.int/homes/ccu/documents/documents2/pi%20training%20may%202014%20hwo%20ccm%20(5).pptx
- Checklist of important recommendations for managing legal issues:
  http://intranet.who.int/homes/ccu/documents/leg%20for%20wrs%20one%20page%20advice.docx
- Library & Resources (LEG intranet site):
  http://intranet.who.int/homes/leg/libraryresources/
Contacts

• **Regional offices:** DAFs, FSOs, Regional Personnel Officers (RPOs)

• **Headquarters**

Privileges and immunities

• Gian Luca Burci (burci@who.int)

• Françoise Mourain-Schut (mourainschutt@who.int)

• Xavier Daney (daneyx@who.int)

Commercial and contractual matters

• Anne Mazur (mazura@who.int)
Evaluation and organizational learning

Background

Strengthening evaluation and organizational learning is a key outcome of the WHO reform process. There has been much recent progress in the evaluation work undertaken in WHO, with critical milestones such as the approval of the Evaluation Policy in 2012, the review and approval by the Executive Board of the first biennial evaluation workplan in May 2014, and the establishment of the Global Network on Evaluation (GNE), coupled with the release of the WHO Evaluation Practice Handbook as an instrument to guide and harmonize evaluation work being conducted across the organization and to support mainstreaming of high quality evaluation work.

To build on this, and to further support the ongoing WHO reform process, the evaluation function was moved from within the Office of Internal Oversight Services to become an independent office to support independent evaluation within the Office of the Director-General. A recent review looked at both the situation in WHO and at best practices and models in other entities, and a framework for strengthening the evaluation function was developed.

The Framework for strengthening evaluation and organizational learning incorporates best practices and models that could be implemented within the WHO context, and will be the instrument to implement the WHO Evaluation Policy. It aims to contribute towards establishing a culture of evaluation at all levels of the Organization, so that evaluation plays a critical role in WHO in improving performance, increasing accountability for results, and promoting organizational learning. Following review by the GPG and governing bodies, the framework is now being operationalized.

Key messages

- Evaluation is intended to provide accountability for achieving results from the use of resources and learning from experience in ways that can be put into practical use. Furthermore, evaluation should influence policy and operational decisions.

- Evaluation, although part of WHO’s broader accountability framework, is distinct from other functions in the oversight spectrum. Whereas audit and the internal control framework focus on compliance, evaluation focuses on results and on understanding what works, why and how.

- Evaluation differs from monitoring and the PB performance assessments, as it gives attention to not only whether expected results are being achieved, but also looks more widely at issues of relevance, context, causality and eventual impact and sustainability. Furthermore, evaluation is an independent exercise, while both monitoring and PBPA are self-assessments.

- Three principal criteria need to be satisfied in order for WHO’s evaluation function and products to be considered of high quality: i.) independence of evaluations and evaluation systems; ii.) credibility of evaluations; and iii.) utility of evaluations. Satisfying these criteria will go a substantial way in building the confidence of Member States and other stakeholders, both in the evaluation function and in the overall work of WHO.
• Coherence and harmonization across the Organization is achieved through adherence to guidance provided in the WHO Evaluation Practice Handbook and the GNE task force on quality assurance.

**Evaluation across the Organization**

• Corporate/centralized evaluations will be managed, commissioned or conducted by the Evaluation Office (EVL). Corporate evaluations include: evaluations linked to a GPW leadership priority; Programme evaluations (focussing on specific programmes); thematic evaluations (topics such as a strategy, new ways of working, cross-cutting-theme or core function) and office-specific evaluations (focus on work of WHO in a country, in a region or HQ in respect of WHO’s core roles, function, objectives and commitments). EVL will also provide technical backstopping and quality assurance to decentralized evaluations in HQ clusters, regional offices and in country offices.

• In addition to EVL, other internal/external resources to help expand evaluation capacity include: designated evaluation focal points in RD’s offices; the Global Network on Evaluation (GNE); an expanding community of practice; an Evaluation Advisory Group (EAG); and a prequalified roster of evaluation experts and institutions (public/private) to support the evaluation work of the organization.

• Decentralized evaluations are evaluations managed, commissioned or conducted outside the central Evaluation Office, and include: programme evaluations; thematic evaluations; or regional or country-office specific evaluations. These will only be considered evaluations if they fulfil the criteria of an independent evaluation. In this instance, the central evaluation office would provide quality assurance and technical backstopping. As far as possible, all decentralized evaluations need to be captured in the biennial workplan that is presented to the January EB at the start of a given biennium.

• Starting with the 2016-17 biennium, it is proposed that a biennial workplan be developed incorporating both the corporate and decentralized evaluations planned in that biennium. The workplan will be developed in consultation with the GPG, ADsG and other relevant staff, including programme directors and heads of country offices especially for decentralized evaluations.

• Draft evaluation reports will be reviewed for quality and utility, circulated for comments and discussed with senior management and other relevant stakeholders, including where appropriate, heads of country offices. Final reports and recommendations/action points will be made available on the EVL website; and an evaluation tracking system will be established.

**Organizational learning and communication**

• Learning should contribute to a culture where evaluation is integral to the planning, design and implementation of policies and programmes.

• Effective feedback loops from evaluation to policy and decision making for evaluation findings to inform key decisions. A number of ways, both formal and informal, to promote and ensure organisational learning. Evaluation findings to also help to sunset or pause implementation, undertake mid-course corrections, or to initiate new activities and programmes.
An important additional route to strengthen the culture of learning, and increase transparency and stakeholder ownership is to communicate evaluation work and findings effectively. Communication efforts will need to consider the range of potential target audiences and the diversity of these audiences when preparing the necessary communication products.

Communication of evaluation results in a timely and effective manner can influence views not only of staff but also of Member States (delegates, parliaments, decision-makers), the broader donor community and other stakeholders. It contributes towards transparency, and building confidence and trust in the work of the organization.

Useful models to communicate WHO’s evaluation work and findings include: annual reports; executive summaries; stakeholder seminars/webinars; Member States’ briefings; and a well-maintained, up-to-date website.

Resources

- WHO Evaluation Policy 2012
- WHO Evaluation Practice Handbook
  [http://apps.who.int/iris/bitstream/10665/96311/1/9789241548687_eng.pdf](http://apps.who.int/iris/bitstream/10665/96311/1/9789241548687_eng.pdf)
- Framework for strengthening evaluation and organizational learning

Contacts

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<tr>
<th>Region</th>
<th>Name</th>
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<tr>
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<td>Eliil Renganathan, Director</td>
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Global Network of Evaluation — contact EVL for more details.
Human resources

Background

The Human Resources Strategy reflects three pillars – Attracting Talent, Retaining Talent (career management) and creating an Enabling Working Environment. Implementation of the strategy is a shared responsibility between the Human Resources function, Management and Staff.

In your role as Head of WHO Country Office, you will find support for implementing the HR Strategy from the Global Human Resources Department (HRD) and your Regional Human Resources Manager (RHRM).

Staff Rules and Regulations

Contractual Arrangements

Please refer to Annex 1 for information about WHO Contractual Arrangements

Further information on post classification:
  eManual III.2.1
  http://intranet.who.int/homes/rco/classification/index.shtml

Conduct and Disciplinary Measures

In cases of suspected wrongdoing, document and report to RHRM and Director of Administration and Finance (DAF) without delay.

Further information:
  eManual III.11

Contract Management

Please refer to Annex 1 for information about WHO Contractual Arrangements

Further information:
  eManual III.4.3

Recruitment, inter-agency transfer, loan & secondment

The recruitment of longer-term positions in the higher and professional categories is undertaken through the harmonized, competitive approach to recruitment. Please refer to Information Note 8/2014 and to the Regional office for advice.

Contact the Regional office for all cases of secondments and loans. Transfers are initiated and handled by the Regional office.

Further information:
  eManual III.4
  eManual III.4.7
Separation
Consult with RHRM for specific separation cases including guidance about Separation by Mutual Agreement (SMA), resignation, termination for reasons of health, unsatisfactory performance and misconduct, abandonment of position and death of a staff member.

Further information:
eManual III.10

Staff Regulations and Staff Rules
The broad principles of Human Resources Policy can be found in the Staff Regulations and Staff Rules. These outline the fundamental conditions of service and the basic rights, duties and obligations of the WHO staff. The Staff Rules implement the provisions of the Staff Regulations.

Heads of WHO Country Office should consult the DAF and RHRM on all issues related to the application of the Staff Regulations and Staff Rules.

Further information:
eManual III.19.1

Operations and Management

Appeals and Grievances
In cases of appeal or application of the WHO policy on Harassment, refer to the Regional office.

Further information:
eManual III.12

Human Resources Actions
Initiate and submit HR Actions in GSM in a timely manner. Check standard operating procedures (SOPs) and user productivity kit (UPKs, online training relevant to GSM processes) for appropriate processing and ensure all required documentation is attached.

Further information:
eManual III.21.1 (SOP)
http://intranet.who.int/tools/gsmupk/toc.html (UPK)

Leave and Absence
Leave and absence management should be closely monitored. Check that leave is entered in the GSM in a timely manner, and that leave records are up to date (see SOPs and UPKs).

Further information:
eManual III.6

Performance Management
All supervisors should make a formal appraisal of the performance of each staff member under their supervision and record this using the electronic performance management and development system, ePMDS+. This assessment is conducted on a yearly basis for fixed-term and continuing staff, and for the duration of the contract for temporary staff.
Entitlements and Compensation

Field Entitlements
Contact RHRM on issues related to danger pay, rest and recuperation, mobility, hardship and security evacuation.

Local Salary Reviews
For information on the rules and procedures, please contact RHRM.

The website of the International Civil Service Commission (ICSC) is also a useful reference (http://icsc.un.org/rootindex.asp)

Special Operations Approach
In the case of non-family duty stations, contact RHRM for information on application and validity of current policies and procedures.

Staff Health and Wellbeing

Medical Examinations
Ensure that staff have their periodic exams when requested by the Regional Staff Physician (RSP).

For medical examinations and preparation to missions (travel medicine), ensure that staff who travel for WHO are prepared (e.g. have a good level of fitness, have received all vaccinations). Please contact the RSP for more information.

Medical Evacuations
All medical evacuations are done in consultation with the Regional Staff Physician.

Occupational Health and Safety
To develop initiatives in the areas of Occupational Health and Safety/ Health Education and Prevention Programmes (e.g. Stress Management), contact the Regional Staff Physician.
**Psychosocial support**

For counselling and support in cases of critical incident, contact the staff counsellor.

*Further information:*
http://intranet.who.int/sites/staffcounsellor/

**Service Incurred Injury**

In cases of Service Incurred Injuries or Diseases/Special Education Grant/ Disabled Child Allowance, please contact the RSP.

*Further information:*
eManual III.7.3 III.3.6 III.3.4

**Sick Leave**

Ensure that sick leave is entered on time and that medical certificates are submitted (in full confidentiality) to the Regional Staff Physician (RSP). Alert the RSP when the sick leave credit is over 3 months in order to initiate the appropriate administrative actions.

*Further information:*
eManual III.6.9 to III.6.11

**Career Development and Learning**

**Corporate Framework**

The Corporate Framework for Learning and Development outlines the approach to learning and development in WHO. Please refer to Information Note 21/2014

*Further information:*
http://intranet.who.int/homes/pml/

**eLearning**

The WHO online eLearning platform and learning management system, *iLearn*, includes mandatory and recommended learning for WHO staff members. Starting October 2014, the platform is being rolled-out to Regional offices. Please contact your Regional staff development focal point for further information.

*Further information:*

**Induction and HWO’s annual induction**

Contact your Regional staff development focal point for information about global and regional induction programmes for members of the Country team. WHO office in Geneva has also launched a WHO Global Induction Programme which is offered on some fixed dates throughout the year. Please consult your Regional staff development focal point for the dates and most up-to-date information.

Specifically for HWO’s, contact Regional staff development focal point for dates of the WHO Global Induction programme, offered annually in Geneva.

*Further information:*
http://intranet.who.int/homes/ccu/induction/
Regional and Country learning activities

Contact Regional staff development focal point for information about available Global and Regional learning opportunities, offered by WHO or other UN affiliated agencies.

Regional Learning Committee

Contact your Regional staff development focal point for information about the Regional learning plan and the availability of funds for learning activities in your country office.

Contact

HQ: Director HRD, Françoise Nocquet, +41 79 594 2872, nocquetf@who.int
Meetings of the WHO Governing Bodies\textsuperscript{3}: The Executive Board and Health Assembly

Background

\textbf{The Executive Board}

- The Executive Board meets twice a year, customarily in January and in May, immediately after the World Health Assembly. It is composed of 34 members. Member States entitled to designate a member of the Board are elected by the Health Assembly for a period of three years. Representatives of all Member States not represented on the Board and Associate Members may participate without vote in the deliberations of meetings of the Board.

- Letters of convocation are circulated to Member States eight weeks before commencement of each regular session. The provisional agenda is circulated to Member States within four weeks of the closure of the previous session.

- The Board appoints its officers (Chairperson, four Vice-Chairpersons, and Rapporteur) from among its members at its May session, with the post of Chairperson being rotated among the six regions. Only Board members can be nominated as officers.

\textbf{World Health Assembly}

- The World Health Assembly meets each year, customarily in May and lasts for either about 6 days, or 10 days in odd years, when the proposed programme budget is considered. The Assembly elects its President and five Vice-Presidents. The post of President is rotated among the six regions.

- Letters of convocation are circulated 60 days before commencement of each regular session. The provisional agenda - prepared by the Board – is dispatched with the convocation letter.

The Assembly is open to Members, Associate Members, Observers, and intergovernmental and nongovernmental organizations admitted into official relations with WHO.

Key messages

Ensure that Member State delegations are briefed on the following:

- For all Health Assemblies, delegations need to provide original credentials from their government before the opening of the Assembly to enable delegations to participate fully in the Assembly. Although a copy of the credential will have been submitted through the online registration system, Member States are required to deliver the original credentials to the Secretariat (Office of the Legal Counsel) before the opening of the session of the Health Assembly.

- The General Committee usually meets on the first morning of the Assembly in Room XII. Member States who are not members of the Committee may be represented, without voting rights, by one member of their delegation.

\footnote{This document refers to the global Governing Bodies. For detailed information on regional committees, contact the respective Regional Offices}
• The main committees of the Assembly are Committee A, which deals predominately with programme and budget matters, and Committee B, which deals with administrative, finance and legal matters. Committee statements are set at three minutes (and are enforced through a traffic light system).

• Technical briefings are part of the official programme of the Assembly and generally take place at lunch time during the first week. Side events are organized during the lunch time and the evening. Information about events is contained in the preliminary journal, which is available on the WHO website meeting documentation page.

• The general discussion (statements by Ministers and Heads of Delegation) generally commences on the afternoon of the first day of the Assembly, after the address of the Director-General. Plenary statements are set at 500-700 words (five minutes), with regional statements set at ten minutes.

The awards ceremony is generally held on Thursday evening in the Assembly Hall.

**Travel**

Ensure that Member State delegations are briefed on the following:

• Board members may make their own travel arrangements between their normal residence and place of the meeting and be reimbursed travel expenses, in accordance with entitlements in Geneva; or make travel arrangements through Amex, the WHO official travel agent.

• Swiss authorities refuse entry to people who do not have the required entry visa. Since 12 December 2008, Switzerland applies the Schengen Agreement regulations concerning visas. As a result, participants requiring a visa to enter Switzerland must obtain a Schengen visa from the Swiss embassy or consulate in, or closest to, their country of residence; it cannot be obtained from the embassy of another Schengen country. Delivery of a Schengen visa may take up to 21 days, so any visa application should be lodged well in advance of the expected date of travel. It is recommended that participants apply for a Schengen visa Type C, which entitles the holder to visit or transit other Schengen States, including neighbouring France. Applicants must attach a visa support letter to their application. Requests for a visa support letter must be addressed to visagbs@who.int at least three weeks in advance of the governing body meeting.

In accordance with resolution WHA50.1, least developed countries may be reimbursed for actual travel expenses of one delegate each, upon their request, and in accordance with entitlements in Geneva. The actual reimbursement is provided in Geneva upon presentation of a receipt, and is restricted to the equivalent of one economy/tourist return ticket from the capital city of the Member State to the place of the session.

**Resources**

- Basic Documents (containing the Rules of Procedure of the Executive Board and Health Assembly): [http://apps.who.int/gb/bd/](http://apps.who.int/gb/bd/)
- Meeting Documentation (including the provisional agenda and guide for delegates): [http://apps.who.int/gb/index.html](http://apps.who.int/gb/index.html)
Contacts

- For a list of speakers for the general discussion, contact: piazzap@who.int
- To request rooms for side events or bilateral meetings, contact: cmpmail@who.int
- Regarding visa requirements, Schengen regulations apply. Send requests for visa support letters to: visagbs@who.int
Communications

Background

WHO has four strategic communications objectives:

1. Provide accurate, accessible, understandable, useable information.
2. Reinforce WHO’s reputation and leadership.
3. Provide all WHO staff with access to the programmatic and organizational information they need.
4. Build networks and capacity of Member States and WHO staff, particularly for proactive communications in disease outbreaks, public health emergencies and humanitarian crises.

DCO provides a full Communications Training Programme Participant Handbook to all HWOs. This contains tips and tools for all aspects of communications, including:

1. “Framing your communications”—developing your Single Overarching Communications Outcome, analyzing the audience and communicating risk.
2. “Developing communication materials and products”—essential elements of public health communications, including putting together a storyline and talking points.
3. “Working with the media”—media spokesperson tools, tips for working with the media and dealing with hard questions.
4. “Communications policy”—approvals and processes.

Start with “WHO Communications Essentials” online

As a first step, all WHO staff are encouraged to complete the communications e-learning course through iLearn: https://who.csod.com/

Key messages

Good communications is a public health tool. Distributing WHO’s public health guidance to the people who need it in a way they can understand it, increases the chance they will take the actions that improve health.

- This requires some analytical work first
  - Who needs the information?
  - What messaging will ensure that they understand what we are saying and what action we want them to take?
  - Where and how do they normally receive information (radio, TV, social media, web sites, from their community etc.)?
- This analysis guides development of materials.
- Bad communications, or the wrong communications, will not benefit public health.
Good communications shows the relevance of WHO’s work and how it contributes to improving health. Consistently reinforcing WHO’s role as the global health leader will increase the likelihood people trust the Organization to protect their health.

- Studies show that, especially in emergencies when stress is high, people will automatically turn to the place they trust most and take the actions recommended by that organization.
- Building that trust consistently in day-to-day situations is essential for ensuring it is in place in emergencies.

For real-time communication to succeed in the world today, we must develop real-time communications inside WHO. When social networks move faster than internal information networks, reputational issues can occur.

- Sharing information across the Organization so all WHO staff can talk about our work and issues in a consistent manner is essential for creating a coordinated and coherent Organization.

Communications is not risk-free; but sometimes NOT communicating can cause more reputational issues than communicating. Reputational issues must be addressed early or problems can be compounded and spread.

- WHO’s communications team can advise on ways to mitigate and manage communications risk.

DCO is available 24/7. If you are concerned about a reputational issue, call immediately. Do not wait for things to get worse – or just hope it will go away. Often the earlier the consultation, the quicker we can stop or reduce the problem.

Resources
- WHO Communications Training Programme Participant Handbook (e-copy)
- Communications policies can be found in the WHO e-manual for communications
  http://emanual.who.int/p05/s02/Pages/default.aspx
- WHO logo and visual identity guidelines
  http://intranet.who.int/homes/dco/logo/
- WHO Communications Essentials e-learning course:
  https://who.csod.com/
- WHO social media policies
  http://intranet.who.int/homes/new/policies/
- WHO social media etiquette
  http://intranet.who.int/homes/new/etiquette/

Contacts
HQ Department of Communications contacts:
- Director: Christy Feig, feigc@who.int
- Coordinator, Messaging & Writing: Sarah Russell, russells@who.int
- Coordinator, Media: Gregory Hartl, hartlg@who.int
• Coordinator, Capacity Building: Gaya Gamhewage, gamhewageg@who.int
• Coordinator, Online Communications: Chris Bailey, baileych@who.int
• Social Media Manager: Monika Gehner, gehnerm@who.int
• Video/Photography Manager: Chris Black, blackc@who.int
• Internal Communications Manager: Joel Schaefer, schaeferj@who.int

Regional Communications Leads:
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• SEARO: Vismita Gupta-Smith, guptasmithv@who.int
• WPRO: Corinne Capuano, capuanoc@who.int
Information technology

Background

The vision of information technology in WHO is to be a world-class information technology organization and the partner of choice within the Secretariat to help achieve goals by leveraging information technologies. The mission is to bring together the geographically dispersed workforce within to collectively and cohesively deliver information management services that help the Organization achieve its goal.

Information technology is the delivery of infrastructure and information systems supporting business processes. The IT function is focused on five key areas:

1. **Infrastructure.** These are services that form the foundation for other services to run. They include connectivity (networks), telephony, meetings, conferences, electronic messaging, file and print services, identity and access management, hosting, and collaboration tools.

2. **Business solutions.** These are applications and tools developed for staff and other partner entities to manage the business by entering data, generating transactions and producing reports.

3. **Support.** Any service, application or tool provided to end users must be supported.

4. **Risks.** Information technology services must be available, reliable and stable. The Organization invests in initiatives to ensure that services run continuously, while protecting its assets and information.

5. **Processes.** In order to ensure that projects are delivered of high quality and on time, that services are operated in a cost-effective way, and that changes do not disrupt staff’s.

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<tr>
<th>INFORMATION MANAGEMENT SERVICES</th>
<th>GLOBAL OPERATIONS SERVICES</th>
<th>INFRASTRUCTURE SERVICES</th>
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<td>Product Management</td>
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<td>Solution Design (Architecture)</td>
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<td>RFI, RFQ, RFP</td>
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<td>Wide Area Network (WAN)</td>
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<td>WAN Performance Management</td>
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<td>Perimeter Security</td>
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6. **IT Composition**: The IT function is distributed across the entire Organization, with support roles carried out in country offices and in central information technology teams located in each of the seven major offices.

**Key messages**

As head of the office:

- Endorse and support the rollout of global initiatives, e.g., managed firewall, managed desktop, global e-mail, etc.
- Ensure that you and CO staff adhere to IT policies.
- Highlight areas of duplication.
- Contact regional office to avail for services to avoid duplications.
- In coordination with the Regional Office, ensure IT infrastructure is up and running.
- In coordination with the Regional Office, look for and negotiate with local providers (e.g. internet backup link) for IT services.
- Set aside budget specifically for IT services such as GPN (if not done by the Regional Office), mobile cost, training.
- Where possible, define IT focal points.
- Ensure that the IT equipment is up to date and up and running.
- Ensure staff can work remotely (staff provisioned with vTokens).
- Maximize as much as possible virtual conferencing in order to reduce travel costs

**IT Policies**

ITT has developed a number of Policies related to information security:

1. Acceptable Use of Information and Communication Systems Policy
2. Global Information Security Policy
3. Access to Information and Systems Policy
4. Information Classification Policy
5. Information Security Incident Management

More information:

- [http://emanual.who.int/P14/Pages/home.aspx](http://emanual.who.int/P14/Pages/home.aspx)
Global IT Roadmap

The WHO IT team globally is mandated to deliver services that:

- **Modernize** the way WHO works, not only through new technology but also with innovation to enhance business efficiency and management.
- **Generate savings** (thereby lowering costs) in reducing duplication and streamlining processes without sacrificing quality of service.
- **Increase the productivity of staff** through the use of IT solutions that will allow them to work faster but smarter and staying ahead by being connected.
- **Harmonize** IT globally through the alignment of programme, services, budgets, and structures leading to a consistent and agreed way of service delivery.

To achieve the mission and work gradually towards becoming an excellent information technology organization, the strategy is to address several key result areas:

- **Staffing for success**. To deliver true value, the Department must have the right set-up. It is therefore critical that key functions, such as solution architecture, information security, business intelligence and a project management office (where there are currently still some gaps), are established and appropriately staffed.

- **Project management**. To deliver projects on time and on budget, it is vital that the “scope–time–resources” triangle of constraint (Figure 2) is managed. A centre of excellence in project management will allow proper capture of requests, assignment of capable project managers (and other resources) to agreed initiatives, and timely monitoring of financial and technical progress. Additionally, the right methods and tools, developed by the centre of excellence, will support project managers and teams in achieving their deliverables.

- **Infrastructure and shared services**. Speed and efficiency in delivering information technology solutions are vital in enabling the Secretariat to be responsive to needs in a changing public health landscape. It is critical that a corporate approach is adhered to and that a corporate information technology team is used to deliver a solid and clear set of shared services. Given a catalogue of such services (see paragraph 11 below), duplication will be avoided and unnecessary parallel information technology spending in other technical units reduced.
- **Business process support.** Technical solutions are not only the means to improve delivery and increase output and productivity. More often than not, business units need to be advised and guided to review current processes, identify bottlenecks and remap processes to generate higher yield. Current (“as-is”) and future (“to-be”) processes need to be documented and, if possible, quantified before any information technology solution is identified. This will ensure cost-effectiveness in delivering the expected results. Information technology resources will be instrumental in advising business units to think about processes and systems as one cohesive solution.

- **Leadership.** Guidance and leadership are needed to increase communication and the “esprit de corps” of the information technology workforce in WHO, so that the vision and direction are shared and realized.

### Resources

- [Global Project Management Site](http://itpmo.who.int/sites/apps/GlobalITPMO/SitePages/WINHome.aspx)
- [EBPBAC21/3 Report on information technology](http://apps.who.int/gb/pbac/pdf_files/pbac21/PBAC21_3-en.pdf)

### Contacts

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- **EMRO:** Mr Maroun Karam ([karamma@who.int](mailto:karamma@who.int))
- **EURO:** Mr Dejan Jakovljevic ([jakovljevicd@who.int](mailto:jakovljevicd@who.int))
- **HQ:** Mr Marc Touitou ([touitoum@who.int](mailto:touitoum@who.int))
- **SEARO:** Mr Henning Brenoe ([brenoeh@who.int](mailto:brenoeh@who.int))
- **WPRO:** Mr Ahmad Partow ([partowa@who.int](mailto:partowa@who.int))

**Global Service Desk** GPN 17000, [globalservicedesk@who.int](mailto:globalservicedesk@who.int)
Staff security

Background

In each country or designated area where the United Nations is present, the senior-most United Nations official is normally appointed in writing by the Secretary-General as the Designated Official for Security, and accredited to the Host Government as such. The Designated Official (DO) is accountable to the Secretary-General, through the Under-Secretary-General for Safety and Security, and is responsible for the security of UN personnel, premises and assets throughout the country or designated area. The Secretary-General delegates to the DO the requisite authority to take decisions in exigent circumstances, including, but not limited to, the mandatory relocation or evacuation of personnel. This authority and decisions taken pursuant to it shall remain subject to the authority and review of the Under-Secretary-General for Safety and Security. The DO is responsible for ensuring that the goal of the UNSMS is met in his/her country or area.

When appointed DO ad interim HWOs are also accountable to the UN Secretariat General for all matters related to their activities as DO a.i.

Key messages

As a member of the Security Management Team (SMT), the HWO should:

- Participate in interagency security and contingency planning and assist in the development of security plans as appropriate.
- Be an active participant in the country Security Management Team (SMT), contributing information particularly from those parts of the country where WHO is present and making recommendations to improve the overall country security management.
- Ensure that decisions made at the SMT are immediately communicated to the country office staff and, as appropriate to staff on mission.
- Assist the DO in developing the MOSS for the country.
- Use the SMT as an opportunity to ensure that WHO’s needs and interests are appropriately addressed in the country security system. Never delegate the responsibility to participate in the SMT to another staff member except during periods of temporary authorized absence.

Security in the regions and the field

The Regional Directors and their Directors of Administration and Finance (DAFs) play key roles in overall regional security management. DAFs:

- Maintain situational awareness of emerging threats and proactively planning.
- Allocate funds to ensure the safety and security of staff throughout the region.
- Ensure the appropriate programming of resources to address security needs in each country of operation, especially those necessary for compliance with minimum operating security standards (MOSS).
• Exercise managerial oversight over the implementation of security measures across the regions.

In countries, the role of the HWO is to:

• Ensure that security is planned for, and that the UNDSS country share and the MOSS compliance are budgeted for.

• Identify locations needing specialized field security staff, in consultation with DAFs, Director OSS (DOSS) and the Coordinator SEC at HQ.

• Execute the day to day operational responsibilities, with the guidance of DAF and SEC FSOs, where necessary and as appropriate, in consultation with the ADG/GMG and the DOSS.

• Understand the role of the Field Security Officer (FSO), which are to:

  ○ Provide support and advice to management, including analysis of possible threats to staff security in the countries of their region.
  ○ Assess security gaps and propose solutions.
  ○ Provide direct support to the field through security assistance mission, training, advice to personnel and security planning.

**Security responsibilities in the field**

HWOs are responsible for the safety and security of WHO staff in the country of their assignment. The HWO is accountable for all WHO staff and dependents present at the duty station. This includes WHO staff on mission and any recognized dependents of WHO staff members assigned elsewhere HWOs should:

• Ensure that staff members complete all mandatory security training and receive a security briefing and country information package upon arrival at the duty station.

• Be informed on all WHO projects, programmes and missions that include field level activities, to ensure adherence to UN security procedures and to verify that adequate provisions are made for staff security. This requires inclusion of a security risk assessment and provisions for appropriate risk mitigation in the field project documentation.

• Be familiar with UN/WHO security policies and procedures and incorporate security considerations in operational planning, to ensure appropriate security measures are in place to protect staff, and that staff comply with security guidelines and procedures established by the DO and UNDSS.

• Ensure the highest level of MOSS compliance by certifying that adequate resources, including from projects and programmes, are in place.

• Establish an appropriate security objective in HWO’s PMDS.

• Appoint a security focal point who assumes, within the limitations of professional expertise, many of the functions of the Field Security Officer (FSO) for any security related projects and to participate in any technical level security working groups on behalf of WHO.

• In the case where specialized security support is required the HWO can request the assistance of a WHO Field Security Officer (FSO) either from the regional office or from HQ. As security profes-
sionals, FSOs have similar qualifications to UNDSS personnel, as well as specific expertise in WHO operations. HWOs should contact the FSO for:

- Technical advice regarding the management of matters pertaining to staff safety.
- To raise awareness of staff security issues, emphasizing the capacity of staff members to play a role in their own safety and security as well as that of their colleagues.
- In country offices with a FSO, the HWO is the direct supervisor. Coordinator SEC provides technical supervision and input with regards to their performance evaluations (PMDS). The FSO in the field must have direct and unmediated access to the HWO. While the FSO’s advice should always be given due consideration, decision-making responsibility lies with the HWO.

- Report all security incidents to the DO, DSS, DAF and to Coordinator SEC at HQ as soon as possible. This will allow the DO, the Regional Office and HQ to provide advice and the necessary assistance should the need arise. In addition this is a requirement for MAIP (Malicious Acts Insurance Policy: see [http://intranet.who.int/homes/irm/maip/](http://intranet.who.int/homes/irm/maip/)) if a staff member is involved in an incident that would fall under the provisions of MAIP.

**Fire safety**

With regards to fire safety, HWOs should:

- Consider fire safety in all WHO offices, guest-houses and warehouses.
  - Put in place an up to date fire safety plan in all offices.
  - Discuss fire safety issues with staff and conduct a fire drill at least one a year.

**Authorization to drive a WHO vehicle**

At the country level, HWOs determine who drives a WHO car and in what circumstances. They must:

- Take responsibility for determining which staff who are not official WHO drivers — if any — should be authorized to use a WHO vehicle. Where necessary, delegate the exercise of this authority in writing to another staff member in the main or sub-office in the country concerned. (The HWO or the person to whom responsibility has been delegated, can also authorize additional staff to drive a WHO vehicle on a case-by-case basis — e.g. when the numbers of official drivers available are not sufficient to meet needs, or for security related purposes, including in situations where a staff member is required to park a WHO vehicle at his/her residence).

- Check that all individuals authorized to drive WHO vehicles are in possession of a valid driving license, recognized in the country concerned. (Since not all international driving licenses are recognized in every country where the Organization operates, ensure local or national authorities have been consulted).

- Seek advice from DAF as needed.
Aviation safety
HWOs should:

- Be aware of the WHO rules regarding aviation safety: WHO, and the other organizations of the United Nations Security Management System, categorize commercial passenger airlines based on an overall safety score produced by FlightSafe Consultants Limited, which employs a quantified process for determining the relative risk of commercial passenger airlines. Based on the resultant total score, airlines are assigned to one or four categories, which WHO defines as:
  - Category A: Use without restriction;
  - Category B: Use if operationally essential and a Category A carrier is not available within a reasonable time frame;
  - Category C: For HQ staff, not to be used without the approval of the ASFP. For non-HQ staff, not to be used without approval of the DAF after the DAF has taken into account the advice of the Aviation Safety Focal Point (ASFP).
  - Category D: Not to be used. However, in a life-threatening situation, a Category C or D airline may be used with the supervisor’s approval. The supervisor must then report the use of the flight to the ASFP as soon as possible.

- Know the Aviation Safety Focal Point: Coordinator SEC — to whom the Director OSS (ASFP) has deputed authority. Consult Coordinator SEC on all aviation safety matters.

Resources
- UN Framework on accountability and WHO e-manual.
- WHO Aviation Safety Guidelines
- PowerPoint presentation “MOSS, DSS and WHO security”

Contacts

Regional offices:
- FSOs
- AFRO: Abdoulaye Doumbia (doumbiaa@who.int)
- EMRO: Angelito Bermudez (bermudezan@who.int)

HQ: HWOs can contact SEC Coordinator Patrick Beaufour on his mobile at any time +41 79 217 34 54 or via email: (beaufourp@who.int / sec@who.int)
### Annex 1: Gender, Equity and Human Rights (GER) essential criteria

23 October 2014, V5-checklist

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<tr>
<th>ENABLING</th>
<th>GER criteria</th>
<th>Yes/No/NA¹</th>
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<tr>
<td><strong>E-1</strong> Programme area sponsored surveys/research/surveillance data is disaggregated by sex and two or more of the following stratifiers: age, rural/urban, household wealth, ethnic group, education.</td>
<td>To mark Yes, the programme area should collect/promote the collection of disaggregated data of at least two or more of the following stratifiers: sex, age, rural/urban, wealth and education, in population/ institution and/or surveillance based data sources related to the health area.</td>
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<tr>
<td><strong>E-2</strong> Capacity building in your health area includes skills or content related to identifying and addressing (a) gender, (b) equity and (c) human rights issues.</td>
<td>To mark Yes, the programme area should have conducted, or intend to conduct, capacity building activities to develop the required skills for identifying and addressing gender, equity, and human rights issues related to the health area.</td>
<td></td>
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<tr>
<td><strong>E-3</strong> Steps have been taken to promote balanced participation of men and women.</td>
<td>To mark Yes, the programme area should have undertaken, or intend to undertake, actions aimed at promoting greater balance in the participation of women and men of affected populations in consultations/policy dialogues/committees, which it convenes.</td>
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<tr>
<td><strong>E-4</strong> Implementation of United Nations recommendations on the right to health have been promoted in my programme area.</td>
<td>To mark Yes, the programme area should promote the implementation of recommendations on the right to health made to Member States as a result of one of the Treaty Body monitoring mechanisms, Special Procedures (e.g. Special Rapporteurs) or Universal Periodic Review.</td>
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¹ For any marked not applicable, please indicate why.
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<th>No.</th>
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| AN-1 | An analysis of how gender influences vulnerability, risk, and health outcomes related to your health area has been conducted. To mark Yes, the programme area should have conducted, or intend to conduct, an analysis (see note i) to identify differences between men and women, due to (i) gender norms, roles, and relations; (ii) differential access to and control over resources and (iii) biological differences, across the life-course, in:  
- Risk factors, exposures and manifestations of health area  
- Severity and frequency of health area  
- Health seeking behaviour  
- Access to care, experiences in health care settings  
- Outcomes and impact of health area. | |
| AN-2 | A quantitative and/or qualitative equity analysis of marginalised/underserved populations’ health needs and risks, related to your health area, has been conducted. To mark Yes, the programme area has conducted, or intends to conduct, an equity analysis which identifies population groups experiencing differential exposure/vulnerability/access/treatment outcomes/consequences, of the health area due to characteristics that may contribute to social exclusion or disadvantage, such as place of residence, race/ethnicity, occupation, gender/sex, religion, education, socio-economic status etc. | |
ENABLING

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<th>No.</th>
<th>GER criteria</th>
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<tr>
<td>AC-1</td>
<td>Actions that mitigate or address ways in which gender influences health needs, risks and outcomes have been developed and implemented. To mark Yes, the programme area should include actions aimed at reducing or mitigate ways in which gender norms/roles/relations negatively impact on benefit, access and use of, health services.</td>
<td></td>
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<tr>
<td>AC-2</td>
<td>Actions targeting marginalised/underserved populations with associated equity targets have been developed and implemented. To mark Yes, the programme area should have implemented, or intend to implement, actions that reduce or mitigate differential exposure/vulnerability/access/treatment outcomes/consequences of the health area of sub-populations, due to characteristics that may contribute to social exclusion or disadvantage, such as place of residence, race/ethnicity, occupation, gender/sex, religion, education, socio-economic status etc. An example of an equity target is: Number of targeted countries have reduced the wealth quintile gap for family planning demand satisfied by a modern method (reduced ratio between the poorest wealth quintile to the percentage in the wealthiest quintile Q1:Q5 ).</td>
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<tr>
<td>AC-3</td>
<td>Steps to ensure the i) availability, ii) accessibility, iii) acceptability, and iv) quality in the provision of healthcare systems and services for marginalised/underserved populations have been implemented in my programme area. To mark Yes, the programme area should implement actions to ensure the i) availability, ii) accessibility, iii) acceptability, and iv) quality in the provision of healthcare systems and services for sub-populations experiencing differential exposure/vulnerability/access/treatment outcomes/consequences of the health area, due to characteristics that may contribute to social exclusion or disadvantage, such as place of residence, race/ethnicity, occupation, gender/sex, religion, education, socio-economic status etc.</td>
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<tr>
<td>AC-4</td>
<td>Actions to address barriers to inclusion and promote participation of marginalised/underserved populations have been developed and implemented in my programme area. To mark Yes, the programme area should take actions to address barriers to inclusion, and promote participation, of sub-populations experiencing differential exposure/vulnerability/access/treatment outcomes/consequences of the health area, due to characteristics that may contribute to social exclusion or disadvantage, such as place of residence, race/ethnicity, occupation, gender/sex, religion, education, socio-economic status etc.</td>
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1. Yes/No/NA: These options allow for a more nuanced assessment of readiness and implementation status.
| No. | GER criteria                                                                                                                                                                                                 | Yes/No/NA
|-----|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------
| R-1 | Programme publications report data disaggregated by sex and two or more of the following stratifiers: age, rural/urban, household wealth, ethnic group, education. To mark Yes, the health programme area should have produced, or intend to produce, publications/reports which include disaggregated data with two or more of the following stratifiers: based on sex, age, rural/urban, wealth. |       |
| R-2 | Programme area communications/publications include information on gender analysis and equity analysis. To mark Yes, the health programme area should have produced, or intend to produce, publications/reports which include data or information on gender analysis. |       |
| R-3 | Programme area communications/publications include reference to international human rights treaties, conventions or standards on the right to health. To mark Yes for Criteria 9, the programme area should make reference to standards enshrined in any of the international human rights frameworks treaties, conventions or standards on the right to health (e.g. UN Convention on the Rights of the Child (CRC), Convention on Ending all forms of Discrimination against Women (CEDAW), UN Convention on the Rights of Persons with Disabilities (CRPD), International Covenant on Economic, Social and Cultural Rights (ICESCR) in programme communications. |       |
Annex 2: WHO Contractual Arrangements

A. Purpose and Scope

This document provides information on the different types of appointments and contracts applicable in the Organization.

B. Types of Contracts

The terms and conditions of service of WHO employees depend, inter alia, on the type of contract they hold. For this reason, this document is divided into the following items:

1. Appointment policies
2. Classification of posts
3. Non-staff contracts
4. Other arrangements

C. Status and Basic Legal Documents

‘Staff member’ means a person appointed by the Director-General other than a consultant, a holder of Agreement for Performance of Work (APW) or a person engaged under a Special Service Agreement (SSA). It also means a person engaged by the Director-General other than those engaged specifically for a conference or a meeting, for auxiliary services or for maintenance duties in field offices or a casual labourer.

WHO’s Staff Regulations and Staff Rules are only applicable to staff members on continuing, fixed-term and temporary appointments. The staff members’ conditions of service are governed by WHO’s Staff Regulations and Staff Rules and the relevant provisions of the e-Manual.

Conditions of service of individuals employed under non-staff contracts, such as Consultants, APW and SSA are set out in the relevant Sections of the e-Manual.

1. APPOINTMENT POLICIES

In July 2007, WHO was the first organization within the UN common system to implement the new contractual framework proposed by the International Civil Service Commission (ICSC) and endorsed by the UN General Assembly. This framework comprises three categories of appointments: continuing appointments, fixed-term appointments and temporary appointments.

Temporary Appointments of 60 days or less
(see III.13.2 Section of the e-Manual)

A temporary appointment of 60 days or less is a time-limited appointment to meet conference and other short-term service needs. Typical examples would be short-term needs arising from unexpected staff absences or in relation to support services to be provided during conferences (e.g., ushers, messengers, guards, audio technicians, typists).

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4This document provides an overview of WHO contractual arrangements to support and facilitate the implementation of WHO human resources policies and procedures. This document is for information only; it is neither authoritative nor binding. This document reflects the WHO statutory texts at the time of writing; however, these texts are revised from time to time. In the case of a conflict between this document and the WHO Staff Regulations and Staff Rules, and e-Manual provisions, the WHO Staff Regulations and Staff Rules, and e-Manual provisions take precedence respectively.

5Contractual framework for staff members
These appointments are not intended for use to address programme or operational emergency needs expected to last for more than 60 days nor for the procurement of expert services for which a consultant contract should be issued. Exceptionally, in the event of a natural disaster or similar emergency situations, a temporary appointment of 60 days or less may be issued pending full assessment of emergency needs in the longer term. However, given the limitations of the social security benefits provided under this type of appointment, appointments of 60 days or less should not be used for assignments to high risk or hazardous duty stations, particularly those in security phase III and above.

When the services of a staff member holding a temporary appointment of 60 days or less are required beyond the maximum 60 day period, and provided that there is no break-in-service\(^6\) between temporary appointments, the staff member may be offered a new temporary appointment under Staff Rule 420.4.

**Temporary Appointments under Staff Rule 420.4**  
*(see Staff Rule 420.4 and III.4.3 Section of the e-Manual)*

A temporary appointment under Staff Rule 420.4 is a time-limited appointment of up to two years. If the temporary appointment is of less than two years, it may be extended, provided that the total duration of uninterrupted service under consecutive temporary appointments does not exceed two years. A staff member who has completed the maximum period of uninterrupted service on one or more temporary appointments may not be re-employed by the Organization unless more than 30 calendar days have elapsed since his/her separation from service.

**Fixed-Term Appointments**  
*(see Staff Rule 420.3 and III.4.3 Section of the e-Manual)*

A fixed-term appointment under Staff Rule 420.3 is a time-limited appointment of one year or more. Any extension is subject to conditions determined by the Director-General.

A fixed-term appointment will be subject to a period of probation, which will be of at least one year and which may be extended for up to two years, when necessary, for adequate evaluation of the staff member’s performance, conduct and suitability to international civil service.

**Continuing Appointments**  
*(see Staff Rule 420.2 and III.4.3 Section of the e-Manual)*

A continuing appointment under Staff Rule 420.2 is an appointment without specified time-limit.

In the context of WHO reform the Organization revised its contractual framework through making the criteria and conditions more rigorous for the granting of a continuing appointment to current staff, and phasing out continuing appointments for future staff members.

Staff members, excluding those referred below, who held a fixed-term appointment on 1 February 2013, are eligible to be granted or considered for a continuing appointment as follows:

(i) If, during the appointment held on 1 February 2013, the staff member reaches a minimum of five years uninterrupted fixed-term active service and has certified satisfactory performance, a continuing appointment shall be granted.

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\(^6\) Periods of non-employment of any duration between temporary appointments will interrupt the continuity of service.
(ii) If, during the appointment held on 1 February 2013, the staff member does not reach five years of uninterrupted fixed-term active service, the staff member shall be considered for a continuing appointment pursuant to conditions and criteria established by the Director-General. For more details on the conversion requirements please refer to the Information Note 28/2014.

The categories of staff members who are not eligible for a continuing appointment include:

(i) Staff members who hold appointments at the level of Deputy Director-General, Assistant Director-General or Regional Director, as specified in Staff Regulation 4.5;
(ii) Staff members on secondment to the Organization; and
(iii) Staff members who did not hold a fixed-term appointment on 1 February 2013.

2. CLASSIFICATION OF POSTS

All posts at Headquarters and in the field are subject to the post classification policy with the following exceptions:

- Posts of Deputy Director-General, Assistant Director-General and Regional Director;
- Posts known as ungraded/unclassified posts, which are established for special purposes by the Director-General;

Temporary posts are subject to classification action upon establishment, but are not subject to reclassification action.

The classification of posts in WHO is governed by Article 13 of the International Civil Service Commission (ICSC) Statute and Rules of Procedure providing that "The ICSC establishes job classification standards for all categories of staff in the UN Common System." as well as WHO Staff Regulations and Staff Rules, and e-Manual.

**Professional Staff**

*(ref. Excerpts from ICSC Classification Manual Vol. 1 Section VII (1994))*

"Professional work is analytical, evaluative, conceptual, interpretative and/or creative and thus requires the application of the basic principles of an organized body of theoretical knowledge, such as a field of science, learning or specialized discipline. It is intricate and involves a level of difficulty and complexity requiring the identification and consideration not only of the interrelationships between its constituent elements, which are of a varied and diverse nature, but also the broader context and perspective within which it is performed, including its impact on, and interrelationship with, the larger objectives and programmes of the Organization. It requires judgment in analyzing and evaluating problems and in decision-making involving discretionary choices between alternative courses of action. “Professional work requires the understanding of an organized body of theoretical knowledge that is of a level equivalent to that represented by a university degree. While this knowledge is customarily and characteristically acquired through formal education, it may, in some fields of learning or specialized disciplines, be acquired through other training, self-study or practical experience.”
**National Professional Officers (NPO)**

(see Staff Rule 1330 and III.13.4 Section of the e-Manual, and WHO/HRD/RCO/Classification intranet website (http://intranet.who.int/homes/rcro/classification)

The Director-General may appoint National Professional Officers to perform work at the professional level where local knowledge, expertise and experience of a national as opposed to an international dimension is required. NPOs are nationals of the country in which they are to serve, are recruited locally and are not subject to assignment to any official-duty station outside their home country.

**General Service Staff**

(ref. ICSC, 2008)

The General Service Category contributes to the execution of the programmes of the organization through work that is procedural, operational and technical in nature. The functions support programme and process continuity and are central to efficient service delivery. The work ranges from routine or repetitive work undertaken in line with detailed instructions, to functions that are varied, complex and para-professional in nature, requiring identification and consideration of alternatives, sometimes requiring analysis, and based on extensive and in-depth knowledge of a specific subject area.

General Service work involves the application of specific knowledge gained through experience and familiarity with the procedures of the organization. The performance of general service functions often requires post-secondary education and technical or administrative training.

**3. NON-STAFF CONTRACTS**

**Introduction**

From time to time, WHO needs extra services provided by individuals other than its own staff members, to assist the WHO Secretariat, the Member States or its external partners for short periods. The extra services are provided by temporary staff members and by non-staff. These extra services enable the Organization to deal with short-term work overload or core activities when it is not possible to create an established post, and to bring in *ad hoc* outside expertise which is not readily available within the Secretariat.

**Non-staff contract types**

There are several categories of temporary personnel who may be regarded as providing temporary assistance or outside expertise. On the one hand, the services may be directly provided by (i) individuals (natural persons), or, on the other hand, by (ii) legal persons, such as firms, institutions or other nonprofit organizations:

(i) The different types of contracts used for temporary assistance or outside expertise are not interchangeable and cannot be used indiscriminately for the same kind of work. They are intended for different purposes and have different conditions of employment, which determine the status of the individual concerned and the recruitment procedures required. In fact, the nature of the assignment is the determining factor for the employee’s status, and consequently the conditions of service.

(ii) The contracting party provides the Organization with its own employees. They perform/deliver services to WHO for a specific period of time during which they are placed under the functional and technical supervision of the Organization, while retaining their employment relationship with the contracting party.

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The present document covers the following types of non-staff contracts established with individuals:

(a) Consultants;
(b) Special Service Agreement (SSA);
(c) Agreement for Performance of Work (APW).

(a) Consultants
(see VI.2.4 Section of the e-Manual)

A consultant is an individual who is a recognized authority or specialist in a specific field, engaged under a temporary contract in a technical advisory or consultative capacity. A consultant must have special skills or knowledge not normally possessed by the staff member of the Organization and performs functions for which there is no continuing need in WHO.

The consultant is engaged for the purpose of performing a specific time-limited piece of work for WHO in a technical advisory capacity or consultative capacity, and normally:

• The nature of the work requires the presence of the individual on WHO premises for more than an occasional visit; and/or
• The work to be performed requires close WHO technical guidance; and/or
• The work requires the individual to undertake travel for WHO, including to areas affected by disease outbreak or areas where a public health problem is prevalent.

(b) Special Services Agreement
(see III.16.3 Section of the e-Manual)

The SSA is a contract between the Organization and a national or resident of a host country for use of his/her services for either long or short assignments on a specific national project or activity. A SSA should only be concluded when the government of the host country is not able to second national civil servants or undertake the direct recruitment of national project personnel under a reimbursable loan agreement, or when it is considered essential to have a direct national, as opposed to an international input. A SSA may be concluded for services of a technical or administrative support nature.

(c) Agreements for Performance of Work (APW)
(see VI.2.3 and VI.2.4 Section of the e-Manual)

The APW is intended for use in arrangements whereby a specific product such as a report, an article, or technical services such as organization of a seminar, or translation and editing, is prepared and delivered by an individual or a firm, without direct supervision by an officer of the Organization. Normally, the individual contractor, or firm will not carry out the work on WHO premises.

Agreements for Performance of Work should not be concluded for work which would typically be carried out under a short-term consultant contract, i.e. work requiring direct supervision by a WHO staff member and presence on WHO premises (see VI.2.4 Section of the e-Manual). In case of doubt, clearance should be sought from Director, Human Resources Management Department (Regional Human Resources Manager) before an agreement is concluded.
4. OTHER ARRANGEMENTS

The Junior Professional Officer (JPO) Programme

(see WHO/HRD/RCO/Classification intranet website (http://intranet.who.int/homes/rco/jpo)

The JPO Programme within WHO is a starting point for young professionals who wish to pursue a career in public health. JPOs are sponsored by their respective governments and some governments also sponsor developing country candidates.

At WHO, JPOs serve at country offices, regional offices and at headquarters. Under the supervision of a senior staff member, JPOs work with international and national staff and are involved in the identification, design, implementation, monitoring and evaluation of WHO programmes. The purposes of assignments vary and may have a country-specific, regional, sector-based or thematic focus.

JPOs are offered one-year fixed-term appointments which are normally extended for a second year (two or three years being the usual length of assignment), subject to satisfactory performance and approval of the donor country. Salaries correspond to those of entry-level UN professional staff (P-1/P-2). JPOs are UNDP staff members, on loan to WHO and are treated as contingent employees for the purpose of WHO’s Global Management System (GSM).

UN Volunteers (UNV)

(see Conditions of Service for international UN Volunteers, September 2008 (http://www.unv.org/how-to-volunteer/cos.html)

An internationally recruited UNV is a professional recruited for her/his qualifications, specialized skills and readiness to serve with volunteer spirit and under volunteer terms without regard for financial benefit. She/he works to realize the broad objectives laid down by the UN Charter for the economic and social advancement of humanity. She/he serves in a country other than that of her/his own nationality. For a candidate to be deployed as an international UNV in a particular country, she/he should not possess the nationality of the country of assignment.

Volunteers

(see III.16.4 Section of the e-Manual)

It is not WHO policy to engage people to carry out work without compensation. There may, however, be occasions when an individual, whose experience and professional background would allow them to make a contribution to the work of a technical programme, could be authorized to carry out specific activities on a voluntary basis on WHO premises under the supervision of a staff member. Volunteers could be on sabbatical leave from either their government or their employing institution and be available for a clearly defined period.

Any offer from a volunteer should be evaluated by the technical programme with a view to ensuring that the experience and professional background of the individual would contribute to the work of the technical programme.

8 In some cases, an international UN Volunteer may be recruited locally, i.e. at the country of deployment. In such cases, the entitlements may vary as indicated specifically in the conditions of service.
**Temporary Advisers**
*(see III.16.1 Section of the e-Manual)*

The term ‘temporary adviser’ applies to persons invited for short periods of not more than sixty consecutive days to give advice or assistance to the Organization. It does not normally apply to persons engaged to give advice or assistance to a Member State. Temporary Advisers are not considered as staff members in any sense and receive neither appointments nor salary.

**Interns**
*(see III.16.4 Section of the e-Manual)*

An intern is a student who is enrolled in a course of study at a university or equivalent institution leading to a formal qualification (graduate or post-graduate); who has completed three years of full-time studies at a university or equivalent institution; and who provides his/her services to WHO without remuneration. Interns do not have the status of WHO staff members and cannot represent the Organization in any official capacity.

An internship is an arrangement between the Organization and an intern whereby an individual’s educational experience is enhanced on a non-remunerated basis through practical assignments and exposure to the WHO’s work.

The duration of WHO internships is between a minimum of six weeks to a maximum of three months. Exceptionally, the Director of the receiving unit may extend an internship up to 6 months to respond to special academic requirements or particular needs of the receiving programme.