HM Government

World Health Organization

UK Institutional Strategy 2008–13

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Contents

Abbreviations

AFRO	WHO Regional Office for Africa
DFID	Department for International Development
DH	Department of Health
EURO	WHO Regional Office for Europe
FCO	Foreign and Commonwealth Office
GAVI	Global Alliance for Vaccines and Immunization
HRP	Special Programme of Research, Development and Research Training in Human Reproduction
IASC	Inter-Agency Standing Committee
MDGs	Millennium Development Goals
MDR-TB	Multi-drug-resistant tuberculosis
MOPAN	Multilateral Organisation Performance Assessment Network
MTSP	Medium-term strategic plan
PAHO	Pan American Health Organization
TDR	Special Programme for Research and Training in Tropical Diseases
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
WHA	World Health Assembly
WHO	World Health Organization
WPRO	WHO Regional Office for the Western Pacific
WR	WHO Representative (the head of a WHO country office)
XDR-TB	Extensive drug-resistant tuberculosis

Foreword

Institutional strategies are negotiated with a number of our key multilateral partners. They set out how the UK and the international agency concerned believe we can work together most effectively to support the goals and objectives of the UK Government and those of the international agency, and monitor the support provided by the UK to that agency.

The WHO Institutional Strategy is a joint UK strategy that has been led by the Department of Health (DH) in England, the Department for International Development (DFID) and the Foreign and Commonwealth Office (FCO). Other government departments (health departments in Scotland, Wales and Northern Ireland, Her Majesty's Treasury, and the Department for Environment, Food and Rural Affairs) have also contributed.

The Institutional Strategy is coherent and consistent with the 2008 UK Government-wide Global Health Strategy, *Health is Global*, and DFID's 2007 Health Strategy, *Working together for better health*.

1. Introduction

1.1 Critical health challenges face the world at the beginning of the 21st century, including:

- the rapid growth of non-communicable diseases and conditions;[1]
- the growth in health inequalities between rich and poor within developed and middle-income countries;
- the still-unchecked HIV/AIDS pandemic;
- the possibility of a successor to the influenza pandemics of the last century;
- the persistence in many countries and many population subgroups of high but preventable levels of mortality and disability from:
  - malaria, tuberculosis (TB), diarrhoea and pneumonia;
  - malnutrition; and
  - childbirth, for both mothers and infants; and
- the threat to health from climate change and other environmental factors.

1.2 The World Health Organization (WHO) is at the heart of the global response to all of these challenges. As the directing and coordinating authority for health within the United Nations (UN) system, WHO is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries, and monitoring and assessing health trends. It is also a key development partner for delivering the health-related Millennium Development Goals (MDGs). WHO, as a co-sponsor of the Joint United Nations Programme on HIV/AIDS (UNAIDS), is central to the global effort to tackle HIV and AIDS.

1 Such as injuries, conditions that occur as a result of violence and mental health disorders.

1.3 This Institutional Strategy sets out the rationale and objectives for UK support to WHO and the way we will work together and with others more effectively. The Strategy also serves as an accountability framework for our support.

1.4 The overarching framework for WHO's work is set out in *Engaging for Health: Eleventh General Programme of Work*, which runs from 2006 to 2015 – coinciding with the timeframe for achieving the MDGs. WHO also has a medium-term strategic plan (MTSP) for 2008 to 2013.[2] The objectives for this UK Institutional Strategy are to:

- set out the UK's vision of WHO's contribution to better global health over the period of the MTSP;
- outline what the UK will do to support WHO in the delivery of its objectives;
- highlight priority areas in the *Eleventh General Programme of Work* on which we will focus; and
- provide a performance monitoring framework to measure progress and account for the UK's investment in WHO's work.[3]

2 The six-year MTSP will be supported by three biennial budgets for 2008–09, 2010–11 and 2012–13. To put the General Programme of Work and the MTSP into action, WHO uses country cooperation strategies and biennial workplans. The relationship between these is shown in Annex 2.

3 In preparing this Institutional Strategy, we commissioned four studies and reviewed DFID's recent WHO Development Effectiveness Summaries and the results of the Multilateral Organisation Performance Assessment Network (MOPAN) surveys. The four studies were: (i) the impact of changes in the global aid architecture on WHO; (ii) an assessment of WHO's performance at country level; (iii) a review of the UK's financing of WHO; and (iv) a review of current governance issues and organisational management performance in WHO. This Strategy also takes account of the 2008 report of the House of Lords Ad-hoc Committee on Intergovernmental Organisations on controlling the global spread of infectious diseases, *Diseases Know No Frontiers*.

2. Delivering better global health – the role of WHO

2.1 The 2008 UK Global Health Strategy, *Health is Global,* sets out the Government's commitment to improving the health of all people in the world and ensuring that our foreign and domestic policies do not undermine global health. Our National Security Strategy highlights pandemic preparedness and tackling conflict, climate change and food security, all of which have an impact on health. WHO is a key partner in the global and UK response to these challenges. DFID's health and research strategies and the UK's 2008 strategy for halting and reversing the spread of HIV in developing countries also highlight WHO's crucial role.

2.2 The UK looks to WHO to:

- help us protect and improve the health of the UK population;
- help improve global health, and particularly to achieve the health-related MDGs; and
- continuously strengthen its own organisational effectiveness and help build a strong and effective reformed UN system.

2.3 As the world's leading public health agency, WHO is today a major force for good in global public health. But it also faces the challenges of a complex organisation in a complex world. Specifically, the UK recognises the following key challenges for WHO and its partners:

- Reducing the highly fragmented nature of **WHO's financing**: This requires attention by WHO, donors and other member states.
- Improving **financial management, human resources and common administration procedures** in a complex organisation: We welcome the aims of the ambitious new Global Management System as an exciting opportunity for WHO to strengthen these areas and identify robust methods for making efficiency savings.
- **Measuring the impact of WHO's technical programmes** in the complex global health field: The quality of technical advice in many countries is very good, but there are occasions when it could be even better. WHO is highly effective at communicating policy options to countries. There is now the opportunity to strengthen help to countries in adopting or

adapting those policies to address specific health problems and to work even more effectively with non-governmental partners in these countries.

- **Alignment and harmonisation with partner countries, and UN reform**: WHO is committed to these principles and there are some impressive examples of success in applying them. In the UK Government's view, the challenge now is to get these principles working at all levels of the organisation and in all regions.
- The **increasing number of global health partnerships and initiatives**: This uses up a growing proportion of WHO's financial and human resources. There is the opportunity for WHO and others to develop a more coherent strategy in this area and to clarify and simplify WHO's role.
- The massive challenge of health in **Africa** and the fact that we are not on track to meet the **health-related MDGs** on this continent: The WHO Regional Office for Africa (AFRO) is a key partner in ensuring that we reach the 2015 targets, and critical to supporting the effectiveness of WHO country offices in Africa.

3. UK support to WHO

3.1 The UK recognises that delivery of WHO objectives is a shared goal which requires leadership from WHO's member states. We will continue to provide WHO with **political, financial** and **technical** support to help it carry out its functions, working closely with others to ensure that WHO can deliver its objectives and meet the challenges set out above.

Political leadership

3.2 The UK is currently on the WHO Executive Board and will remain on the Board until 2010. We will work through the **Executive Board and World Health Assembly (WHA)**:

- to support WHO as the global leader on health;
- to examine WHO business robustly, as a good board member, challenging where necessary and working constructively to achieve global consensus on measures to promote good global health;
- to encourage progress against the General Programme of Work, the MTSP and WHO's workplans – encouraging an ever more effective WHO;
- to demand the highest standards of ethical and evidence-based public health policy; and
- to promote the principles, priorities and direction set out in this Institutional Strategy.

3.3 We will work closely with European Union (EU) countries on the Executive Board and in the WHA, ensuring effective communication through the EU Presidency.

3.4 It is important that the UK supports WHO as one organisation, encouraging policy coherence across WHO's regional offices and between the regional offices and headquarters. Our engagement with all **regional offices** will be directed by the principles and priorities set out in this Institutional Strategy.

3.5 The UK is a member of the WHO Europe Region (EURO), and through our Overseas Territories, of the Pan American Health Organization (PAHO)

and the Western Pacific Region (WPRO). We will continue to participate fully in EURO and take up our place when we are members of its Standing Committee. We will work closely with the Overseas Territories when conducting PAHO and WPRO business.

3.6 The UK will step up its engagement with AFRO in support of the Regional Director's reforms, particularly those consistent with UN reform.

3.7 We have close partnerships with a number of WHO's **country offices**. These are closest in countries where DFID operates, but elsewhere the FCO engages with WHO offices and UN country teams as necessary. DFID country offices and FCO posts will also work to promote the objectives set out in this Strategy. Country offices and posts will be important in assessing progress in delivering the MTSP and the Institutional Strategy.

3.8 We will work with **other UN agencies, the World Bank, the EU** and **member states** of WHO to ensure that they are supporting the work of WHO effectively. We will encourage WHO to work closely with them and also to develop and sustain partnerships with academia, industry, the private sector, foundations, the non-governmental organisation sector and the media.

Financial support

3.9 Improving the health of the UK population, improving global health and meeting the MDGs are central objectives for the UK Government. In the biennium 2006–07, the UK provided 7% of WHO's income – US$358 million. Our funding consists of assessed contributions (our obligatory subscription which is not earmarked for specific activities) and voluntary contributions. The latter have either been earmarked for specific projects, programmes and partnerships, or unearmarked (as core voluntary contribution funding). Details of the flows of funds from the UK to WHO in recent years are shown in Annex 3.

3.10 Over the last 10 years, the proportion of WHO's funding that is earmarked has risen steadily. This makes it increasingly difficult for WHO to plan for and resource effectively over the longer term the full range of priorities set by its member states. The UK recognises the importance of increasing levels of predictable, multiyear, unearmarked funding if WHO is to take forward the actions set out in the MTSP. However, earmarked funding will continue to have a role to play in the financing of WHO, for example to scale up new areas of work developing in response to a changing global context.

3.11 The UK is committed to increasing the effectiveness of international institutions. For agencies that are well managed and delivering outcomes, DFID will seek to increase the funding it provides as voluntary core funds. This will be linked to an agency's performance against the performance framework. Where an agency performs well, this could also lead to additional core funds and, where feasible, increased consolidation of funding from DFID. This is consistent with WHO's own desire to increase the percentage of core funding. We will use annual reviews of the performance framework in Annex 1 to make the case progressively for doing this. However, in certain priority areas, we anticipate that some earmarked funding will need to be retained.

3.12 At the country level, our medium-term objective is to move away from financing individual projects and towards providing unearmarked funding to the MTSP through the biennial programme budgets. By the end of the period covered by the MTSP, we expect to fund WHO in-country through a pooled UN country team fund. Our eventual goal is that the only area where the UK would be providing earmarked funding through WHO at country level would be in response to a public health emergency.

3.13 In order to coordinate UK support better, avoid the need for different types of memoranda of understanding for each financial transaction, and simplify reporting arrangements, the UK will work with WHO to develop an overarching framework agreement.

Technical leadership

3.14 The UK will continue to support WHO's global leadership role in setting health standards by sharing its professional, clinical, academic and governmental expertise. Sixty-four UK institutes currently work with WHO as collaborating centres (the third largest number after the USA and China). Collaborating centres provide strategic support to WHO in fulfilling its mandate and implementing programmes, as well as in developing and strengthening institutional capacity in regions and countries. The main functions of collaborating centres are standardisation, synthesising and disseminating scientific and technical information, provision of services (for example epidemiological surveillance and laboratory support), research, training and coordinating joint activities, and technical cooperation in national health development. Collaborating centres enable WHO to access high-quality support worldwide.

3.15 Collaborating centres gain enhanced visibility and recognition, including for the health issues on which they work, as well as increased opportunities to exchange information and develop technical cooperation with other institutions, in particular at international level, and to mobilise additional resources from funding partners.

3.16 Individuals within the UK health departments, DFID, the NHS and agencies such as the Health Protection Agency, work with WHO through technical committees, steering groups, advisory groups and secondments. We will look at ways to increase opportunities for institutions and individuals to contribute to the work of WHO.

4. Priority areas

4.1 The UK, with other member states, approved the MTSP at the 2007 WHA. The MTSP has 13 objectives and 80 sub-objectives. It has 242 indicators, as well as targets for 2009 and 2013. The MTSP is an important step forward in WHO's results-based management and planning, and will be used as the basis for monitoring and assessing WHO's performance. It is the source of the majority of indicators used in the performance framework in Annex 1.

4.2 WHO's 10-year *Eleventh General Programme of Work* has three broad areas:

- **fundamental needs:** health development and health security;
- **strategic issues:** strengthening health systems and gathering and analysing the evidence needed to set priorities and measure progress; and
- **operations:** fostering partnership and collaboration, strong governance and ensuring that WHO is a learning organisation.

4.3 Based on these three areas, the priority objectives outlined below for this Institutional Strategy were selected after discussion with WHO because they:

- are particularly important to the UK;
- are specific areas where we can work together to deliver; or
- tackle institutional problems that threaten the delivery of the MTSP.

Fundamental needs: health development and health security

Institutional Strategy objectives

- Health and development: WHO makes a demonstrable contribution to achieving the MDGs.
- Global health security: WHO develops clear guidance and support for member states to help them respond to emerging threats to global health security.

4.4 We are committed to ensuring global pandemic preparedness and look to WHO to continue to show leadership here. The International Health

Regulations are fundamental to global public health security; the UK will work with WHO on their implementation. We are also committed to taking forward the 2008 WHA resolution 61.19 on health and climate change and to developing a clear plan for taking forward the recommendations of the WHO Commission on Social Determinants of Health. Because so many sectors affect health, the UK sees many opportunities for WHO to work closely with leaders from other sectors – particularly at country level.

4.5 We welcome the increased focus on addressing the rise of non-communicable disease and the factors (including tobacco, obesity and alcohol abuse) that cause it. We will collaborate on taking forward the *Action Plan for the Global Strategy for the Prevention and Control of Non-communicable Diseases* and encourage WHO to devote adequate resources to this area.

4.6 Health is a key element in the fight against poverty. The UK supports WHO's leadership in improving health in developing countries and recognises its crucial role in helping to deliver the MDGs, particularly the health-related MDGs to reduce child mortality, to improve maternal health, and to combat HIV/AIDS, malaria, TB – including the threat posed by multi-drug-resistant and extensive drug-resistant (MDR/XDR) strains of TB – and other diseases such as polio and neglected tropical diseases.

4.7 We strongly support the priority set out by the Director General on improving women's health. It is particularly important that women are able to access safe sexual and reproductive health services, that WHO encourages member states to respect the sexual and reproductive health rights of women, and that WHO fully resources and implements its sexual and reproductive health strategy, including issues such as tackling unsafe abortion.

4.8 Much effective work has been done by WHO in defining approaches to and setting standards for dealing with public health and humanitarian emergencies. WHO is the global cluster lead among the members of the Inter-Agency Standing Committee (IASC) for health in humanitarian emergency settings.[4] We therefore look to WHO to deliver on the IASC global health cluster commitments. Leading on humanitarian issues is a relatively new role for WHO and a complex one. This will require balancing its traditional role of working with governments with the need to uphold humanitarian principles such as independence, impartiality and neutrality.

4 There are 11 UN members and 20 non-UN members. Details are on www.humanitarianreform.org/humanitarianreform/Default.aspx?tabid=75 as are the global health cluster commitments.

Strategic issues: strengthening health systems and gathering and analysing the evidence needed to set priorities and measure progress

Institutional Strategy objectives

- Health systems: WHO works closely with governments, the Head of Agencies group (Health8) and others to promote universal access to safe and effective healthcare through adequately resourced health systems.
- WHO demonstrates the use of evidence in all guidance and activities.

4.9 The UK believes it is essential that a commitment to strengthening health systems underpins all the MTSP strategic objectives: without strong health systems, effective implementation of the policies and standards work set out in the MTSP will be impossible. Close collaboration with the World Bank is especially important in building health system capacity in middle- and low-income countries.

4.10 The International Health Partnership has a crucial role to play in encouraging development partners to work better together in the health sector, to focus on improving health systems as a whole rather than on individual diseases or issues, and to develop and support countries' own health plans.

4.11 We will also continue to provide commitment and leadership through WHO's World Alliance for Patient Safety to make healthcare systems throughout the world safer.

4.12 We will continue to work with WHO as it develops good practice on health systems, for example on the follow-up to the EURO's 2008 conference, Health Systems for Health and Wealth.

4.13 The UK has been a top investor in international health research, including the Special Programmes for Research, Development and Research Training in Human Reproduction (HRP) and Research and Training in Tropical Diseases (TDR), housed in WHO. We welcome WHO's plans for a new research strategy which will clarify its position in the complex global health research landscape and build and strengthen the research culture within WHO.

Operations: fostering partnership and collaboration, strong governance and ensuring that WHO is a learning organisation

Institutional Strategy objectives

- Management of partnerships for aid effectiveness: WHO provides leadership together with the World Bank in fostering greater coherence within the UN and international health architecture in aligning support by national strategies in line with the Paris Declaration on Aid Effectiveness.
- WHO is increasingly seen to be an effective and efficient organisation at the regional and country level.
- Demonstrable improvement in WHO's internal efficiency.

Championing harmonisation and alignment[5]

4.14 WHO is a key partner in championing harmonisation and alignment of those working in health at global, regional and country level. The UK welcomes WHO participation in the Head of Agencies group (Health8)[6] which aims to improve global health governance.

4.15 It is important for WHO to rationalise and clarify its engagement with the many global health partnerships, streamlining its work with them and ensuring they support the health plans of individual countries.

4.16 As a co-sponsor of UNAIDS, WHO's full participation will be key to the success of the new joint UN teams at the country level, which aim to improve collaboration and cooperation between the UN agencies responding to AIDS.

Active and full participation in UN reform

4.17 The UK is committed to getting UN agencies to work better together as part of our efforts to make the international institutions fit for the 21st century. We believe WHO, as the largest specialised UN agency, has an important leadership role in this. The UK is a strong supporter of the 'One UN' approach at country level.[7] WHO is crucial to ensuring that the 'One UN' approach is successfully rolled out at country level, and we believe it

5 'Harmonisation and alignment' refers to donors harmonising their policies and procedures and aligning their development assistance with countries' own development strategies.

6 WHO, World Bank, Gates Foundation, GAVI Alliance, Global Fund, UNICEF, United Nations Population Fund, UNAIDS.

7 *Delivering as One*. Report of the Secretary-General's High-level Panel, 2006.

is important that WHO's funding in-country is increasingly drawn from the 'One UN' country budget.

Improving performance at regional level

4.18 The effectiveness of WHO's regional offices is central to its overall performance, given its regional governance structures and the cross-country support provided to country offices. There is an increased need for WHO to provide leadership and support across the health sector at regional and country levels and to work even more effectively with other UN partners. We look to WHO to define clearly the role of the regional and country offices in implementing the International Health Partnership and provide the right incentives for their engagement.

Improving performance at country level

4.19 We support WHO as it moves towards health coordination strategies that promote partnership and alignment with national health strategic plans. It is important that WHO Representatives (WRs) see harmonisation as their key role. As UN reform gathers pace, we need to work towards WHO's country plans being fully incorporated into the 'One UN' country programme.

4.20 The WR is key to an effective WHO country office. WR recruitment and appointment is a joint process between the member state concerned, the WHO regional office and the Director General. The process can be subject to considerable pressures and we welcome the commitment to transparent merit-based procedures.

Results-based management and results focus

4.21 The framework in Annex 2 provides the basis for results-based management. There is evidence of good progress in planning, resource allocation and management. It is important that results are available in time to feed into the latest biennial work plans. Results-based management will be strengthened by improving the quality of the baseline data in the MTSP and the reporting of results. We will work closely with WHO on this.

Administrative and management reform

4.22 We welcome the efficiency savings from moving much of WHO's administration to Malaysia and the introduction of the new Global Management System. We will work with WHO and others to identify clear efficiency targets that demonstrate administrative savings against total programmatic expenditure. We also welcome human resource reforms such

as contract reform, personal development plans, staff rotation and staff development programmes. We encourage WHO to develop a corporate-wide human resource strategy and undertake further reforms to enhance quality and performance management of staff.

4.23 We believe WHO would benefit from simplified and harmonised business practices, including the International Public Sector Accounting Standards and Enterprise Resource Planning. We will work with WHO and other countries to improve WHO's governance, including through the establishment of a new independent, expert audit committee. As part of WHO's commitment in 2007 to a UN-wide ethical code, we consider that it is important to see WHO strengthen its arrangements in this area.

5 Monitoring and evaluation

5.1 The Institutional Strategy provides the opportunity for greater coherence and consistency in the way that UK government departments engage with WHO at all levels. To support this process and encourage consistency across government, DH, DFID and FCO will hold regular meetings at official level to ensure we are supporting WHO effectively across government.

5.2 The monitoring process will be as follows:

i) The Institutional Strategy will be monitored on an annual basis against the performance framework in Annex 1. As far as possible we will use data produced by WHO, such as the biennial programme budget performance reviews and biennial medium-term reviews. We would expect financial reviews to be based on reports going to the Executive Board and the WHA. Inputs will also be sought from DH, DFID (including DFID's country health advisers), FCO and independent reviews such as those of the Multilateral Organisation Performance Assessment Network (MOPAN). We will also consult with the UK devolved administrations.

ii) Based on this annual monitoring, a joint working-level review meeting between WHO and the UK (DH, DFID and FCO) will consider actions required to meet off-track indicators, and whether the indicators are appropriate for the year ahead.

iii) A high-level bilateral meeting between the UK (DH, DFID and FCO) and WHO will conclude the review.

Annex 1: Joint UK institutional strategy performance framework

Narrative summary	Core function/ outcome area	Verifiable indicators	Target						Means of verification	Notes
			2008	2009	2010	2011	2012	2013		
Goal										
Improve global and UK health	Effective and timely support to delivering the UK's Global Health Strategy	Progress on MDGs 4, 5 and 6; progress in delivery of domestic health Public Service Agreements				**(See note 2 on all 2011 targets)**				Goal is the same as for the UK government-wide Global Health Strategy
Purpose (see note 4)										
WHO is increasingly effective and efficient in fulfilling its 6 core functions (CFs)	CF1. Providing leadership on matters critical to health and engaging in partnerships where joint action is needed	Number of member states that **have developed with WHO support** a policy on achieving universal access to sexual and reproductive health. **Baseline: 20 countries**		30 countries		40 countries		50 countries	Programme Budget performance reports	MTSP indicator 4.1.2., in amended MTSP (revised version for 2010–11 Programme Budget)
	CF2. Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge	Number of new research centres that have received an initial grant for institutional development and support. **Baseline: none**		8 centres		16 centres		24 centres	Programme Budget performance reports	MTSP indicator 4.2.1 in amended MTSP (relates to HRP)
	CF3. Setting norms and standards, and promoting and monitoring their implementation	Number of new or updated global norms and quality standards for medicines and diagnostic tools for HIV/AIDS, TB and malaria. **Baseline: 5 global standards**		10 new standards		Updated when 2010–11 Programme Budget finalised		20 new standards	Programme Budget performance reports	MTSP indicator 2.3.1
	CF4. Articulating ethical and evidence-based policy options	Number of WHO regions with a regional strategy for addressing social and economic determinants of health as identified in the Report of the Commission on the Social Determinants of Health endorsed by the Director General. **Baseline: 2 regions**		5 regions		Updated when 2010–11 Programme Budget finalised		6 regions	Programme Budget performance reports	MTSP indicator 7.1.1 in amended MTSP (revised 2010–11 indicator)
	CF5. Providing technical support, catalysing change and building sustainable institutional capacity	Number of member states that have expanded coverage of the integrated management of childhood illness to more than 75% of target districts. **Baseline: 20 countries**		30 countries		45 countries		60 countries	Programme Budget performance reports	MTSP indicator 4.5.2 in amended MTSP
	CF6. Monitoring the health situation and assessing health needs	Proportion of emergencies for which the health and nutritional status of affected population is assessed and tracked. **Baseline: 15% of emergencies**		60% of emergencies		Updated when 2010–11 Programme Budget finalised		80% of emergencies	Programme Budget performance reports	MTSP indicator 5.2.1. This indicator will change for the 2010–11 Programme Budget

Narrative summary	Core function/ outcome area	Verifiable indicators	Target						Means of verification	Notes
			2008	2009	2010	2011	2012	2013		
Priority areas/objectives										
Health and development										
1. WHO makes a demonstrable contribution to achieving the MDGs	Communicable diseases (includes malaria, TB and polio)	1.1 Proportion of endemic countries that have achieved their national intervention targets for malaria. **Baseline: 5%**		50%		Updated when 2010–11 Programme Budget finalised		100%	Programme Budget performance reports	MTSP indicator 2.1.2 in amended MTSP
	SRHR	1.2 WHO Strategic Objective (SO) 4 (see note 3) with expenditure levels meeting Programme Budget targets. **Baseline: 70%**	75%	80%		Updated when 2010–11 Programme Budget finalised		100%	Reporting for MTSP indicator 13.2.2, but specifically for SO4.	In MTSP, overall indicator and target for SO13 and Organisation-Wide Expected Result (OWER) 13.2.2 deals with expenditure levels for all SOs. SO4 deals with key stages of life, which includes SRH.
Global health security										
2. WHO develops clear guidance and support to member states to respond to emerging threats to global health security	Climate change	2.1 Number of countries that have implemented plans to enable the health sector to adapt to the health effects of climate change				Updated when 2010–11 Programme Budget finalised			2011–13 Programme Budget performance reports	MTSP 8.6.2 from amended MTSP. New indicator for 2010–11. Targets will be set at 2009 WHA
	Pandemic influenza	2.2 Number of member states that have completed the assessment and developed a national action plan to achieve core capacities for surveillance and response, in line with their obligations under the 2005 International Health Regulations. **Baseline: 50 countries**		180 countries		Updated when 2010–11 Programme Budget finalised		193 countries	Programme Budget performance reports	MTSP indicator 1.6.1
	Humanitarian response	2.3 Proportion of member states affected by acute-onset emergencies and those with ongoing emergencies and a humanitarian coordinator in which the IASC Humanitarian Health Cluster is operational in line with IASC cluster standards. **Baseline: 30% of countries**	5-year Health Action in Crisis strategic plan drafted by December 2008	60% of countries	Indicator reported on course	80% of countries	Indicator reported on course	100% of countries	2008 target reported by DFID/CHASE department. Other targets verified through Programme Budget performance reports	2008 target relates to letter sent by Director of UNCHD/ DFID to WHO/HAC. 2010–11 MTSP indicator 5.6.2. 'Indicator reported on course' implies a 'green' traffic light in WHO's Mid-Term Review of the biennial Programme Budget.

Narrative summary	Core function/ outcome area	Verifiable indicators	Target						Means of verification	Notes
			2008	2009	2010	2011	2012	2013		
Health systems										
3. WHO works closely with governments, Health8 and others to promote universal access to safe and effective healthcare through adequately resourced health systems	Health systems	3.1 WHO makes necessary changes to implement the International Health Partnership (IHP)		WHO implements recommendations from the 2008 review of IHP as agreed in the Scaling up Reference Group and by WHO senior management					WHO reports on implementation of the IHP	New area of work for WHO. No IHP indicator in MTSP
	Gender strategy	3.2 Number of member states supported by WHO that have conducted one or more gender-mainstreaming activities in health programmes that have introduced gender mainstreaming into health programmes. **Baseline: 83 countries**	2009 target reported on course	107 countries		Updated when 2010–11 Programme Budget finalised		155 countries	Programme Budget performance reports	Indicator 7.5.2 from amended MTSP being revised for 2010–11 Programme Budget; targets for 2011–13 set at 2009 WHA
	Health systems – secondary care	3.3 Number of countries participating in global patient safety challenges and other global safety initiatives, including research and measurement. **Baseline: 30 countries**		45 countries		Updated when 2010–11 Programme Budget finalised		100% increase	Programme Budget performance reports	MTSP indicator 10.13.2 from amended MTSP. Revised 2010–11 indicator. Indicator addresses secondary care. Primary care issues picked up in the IHP indicator
Gathering and analysis of evidence										
4. WHO demonstrates the use of evidence in all guidance and activities	HRP and TDR	4.1 OWER 4.2 with expenditure levels meeting Programme Budget targets. **Baseline: 70%**		80%		Updated when 2010–11 Programme Budget finalised		100%	Programme Budget performance reports	The indicator assesses the level of funding for research in maternal, child and sexual and reproductive health. Target from 13.2.2

Narrative summary	Core function/ outcome area	Verifiable indicators	Target						Means of verification	Notes
			2008	2009	2010	2011	2012	2013		
Management of partnerships for aid effectiveness										
5. WHO provides leadership together with the World Bank in fostering greater coherence within the UN and international health architecture in aligning support by national strategies in line with the Paris Declaration on Aid Effectiveness	IHP	5.1 Number of IHP country compacts signed	3 compacts signed	12–15 compacts signed in total					WHO IHP reporting	New area of work for WHO which will be added to the revision of the MTSP indicators for Programme Budget 2010–11
	UN reform/system-wide coherence	5.2 Improved WHO coherence with UN country teams in all countries by 2013	Agreement on an action plan to deliver an effective delineation of UNDP's system-wide role from its operational role	Country cooperation Strategies fully coherent with 'One UN' plans in pilot countries. All WHO country representatives to report to the RC on matters related to the working of the UN country team	To be agreed at the 2009 annual review meeting	To be agreed at the annual review meetings	To be agreed at the annual review meetings	To be agreed at the annual review meetings	2008: UNDP/ UNDG correspondence. 2009: direct contact with country offices. RC system target to be verified by DFID in 10 agreed target countries	New area of work for WHO which will be added to the revision of the MTSP indicators for Programme Budget 2010–11. The second half of the 2009 indicator comes from the UNDG agreed Management and Accountability System of the UN Development and RC System, including the 'functional firewall for the RC System', p.8 point 5, which reads "The reporting relationships for all managers/representatives in the country team should be similar with respect to the RC. All agency country representatives in the country team would report to the RC on matters related to the working of the country team and implementation of the country programme and strategy. Concurrently the country representatives report to their respective regional managers and headquarters organizations on matters relating to the details of their particular organization's operations. This model of these reporting arrangements vis-a-vis the RC to be reviewed and amended as needed by the end of 2009."
6. WHO is increasingly seen to be an effective and efficient organisation at the regional and country level	Country-level performance	6.1 Proportion of WHO Representatives rated as effective by partners in-country in delivering technical support, coordination and UN reform		Targets based on MOPAN survey developed to assess WR performance					To be developed during 2008–09.	The UK will work with WHO to develop a suitable indicator in this area. Potential indicator to be taken from MOPAN survey (draft 13A: Multilateral organisation has reputation among its stakeholders for high-quality, valued policy dialogue inputs)

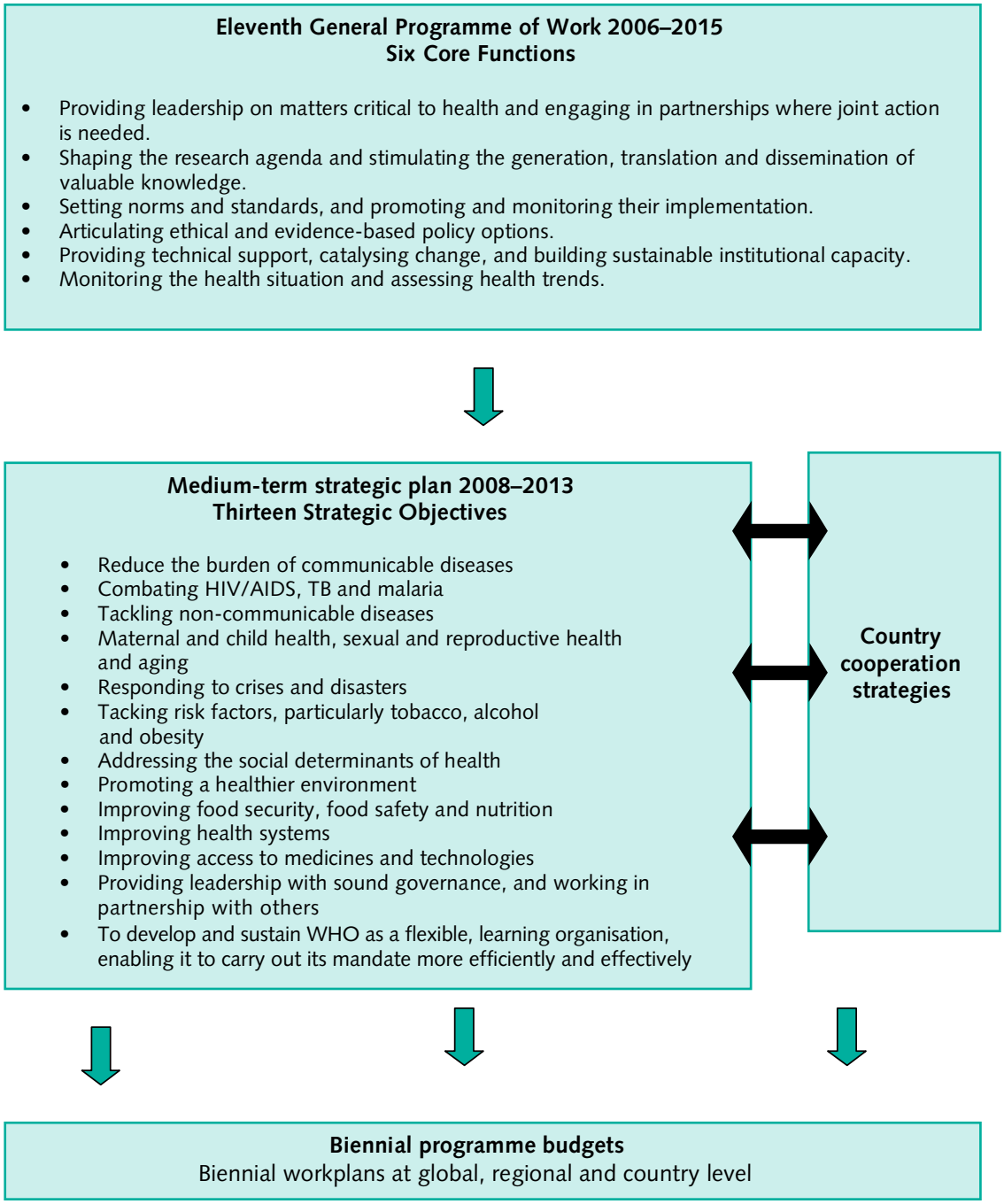
Narrative summary	Core function/ outcome area	Verifiable indicators	Target						Means of verification	Notes
			2008	2009	2010	2011	2012	2013		
Internal efficiency and performance of WHO										
7. Demonstrable improvement in WHO's internal efficiency	Results-based management	7.1 WHO produces clear reporting on results achieved at SO level, OWER level, and Office-Specific Expected Results (OSER) level	System established to measure and report on performance at OSER level						2008: Internal WHO communication. Subsequent years defined at first review	Use of WHO's Key Office Performance Indicators (KOPI). WHO currently measures and reports to governance bodies at the higher OWER level, this misses details of outcomes at a country or office level.
		7.2 Cost-effectiveness of the enabling functions of the organisation, i.e. the share of the overall budget spent on SO13 relative to the total WHO budget. **Baseline: 14.5%**	Indicator reported on course	14%	Indicator reported on course	13%	Indicator reported on course	Target 12% in 2013	Programme Budget performance reports	Indicator responds to need for an indicator on WHO efficiency savings. MTSP, SO13 overall indicator, cost savings related to GSM will not come on line until 2010–11. Subsequent annual reviews could propose a sharpened indicator
	Human resources	7.3 Human resources reforms including transparent processes for selection including the advertisement of WHO country representatives and all senior posts (P5 and above), with transparent criteria and appointment on merit based on independent review, and the improvement of the Performance Management and Development System (PMDS)	Definition of appropriate spread of assessments and related targets established	50% of appointments conducted through transparent mechanism	Process fully in place by 2010				KOPI	
	Business practice and standards	7.4 WHO governance and oversight improved through the creation of an independent, expert audit committee with ToRs in line with current UN best practice, and compliance with International Public Sector Accounting Standards (IPSAS)		Substantive discussion at the 2009 PBAC on Audit Committee proposals	Audit Committee established by January 2010 Executive Board. 100% WHO compliance with IPSAS				Papers presented to the PBAC and Board	MTSP IPSAS indicators are 13.2.21 and 13.4.3
Number of targets per year (for 2009 onwards this number may change as targets are defined)			8	14						

Narrative summary	Core function/ outcome area	Verifiable indicators	Target						Means of verification	Notes
			2008	2009	2010	2011	2012	2013		
Note on highlighted indicators	Indicators not currently in WHO planning documents, MTSP, MTSP rewrite, or KOPI									

Note 1: 7 outputs, 16 indicators. **Note 2**: The target for 2011 will be approved once the Programme Budget for 2010–11 is approved by the 2009 WHA. These targets will be added to the PF at the first review meeting scheduled for June 2009. **Note 3:** SO4: To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals. **Note 4:** Purpose level indicators have been taken directly from WHO's MTSP. These are a sample of indicators to track progress of WHO across its core functions. A different set of indicators at this level can be identified each year at the time of the annual review to monitor over the subsequent year.

Note 5.The specific targets for May 2009 for additional performance funding in 2009, which are based on targets in the performance framework, are: a) instructions issued to all WHO regional and county offices to participate fully in UN country team efforts to take forward the Management and Accountability System of the UN Development and RC System; b) WHO and World Bank leadership of the IHP lead to five country compacts signed; and c) WHO demonstrates progress on the Health Action in Crisis strategic plan, with an improvement from 30% to 45% of countries with humanitarian crises in which a humanitarian health cluster is operational and effective.

Annex 2: WHO strategic and operational framework



Annex 3: Financing flows to WHO

As part of developing the Institutional Strategy we undertook four studies, one of which was concerned with the way WHO is financed. The data in this annex come from that work.

WHO's income is growing rapidly. It was around US$1.8 billion for the biennium 1998–99 and was just over $4.2 billion for the biennium 2006–07.

WHO receives its income in different ways. Its regular budget is unearmarked and financed by obligatory assessed contributions. Once the WHA approves the programme budget, a calculation of each member state's contribution is made based on the standard UN formula and each state is invoiced in January each year. However, a far greater amount of WHO's income comes from voluntary contributions, most of which are earmarked for specific projects and programmes. In 2006–07 only 16% of WHO income came from assessed contributions. Voluntary contributions are made on the basis of agreements between the WHO and different public and private donors. WHO also receives income for non-WHO programme activities, such as UNAIDS.

Figure 1 shows current and predicted contributions to WHO. The largest area of growth has been for global health partnerships and initiatives and WHO's outbreak and emergency response.

Figure 1: Current and predicted contributions to WHO

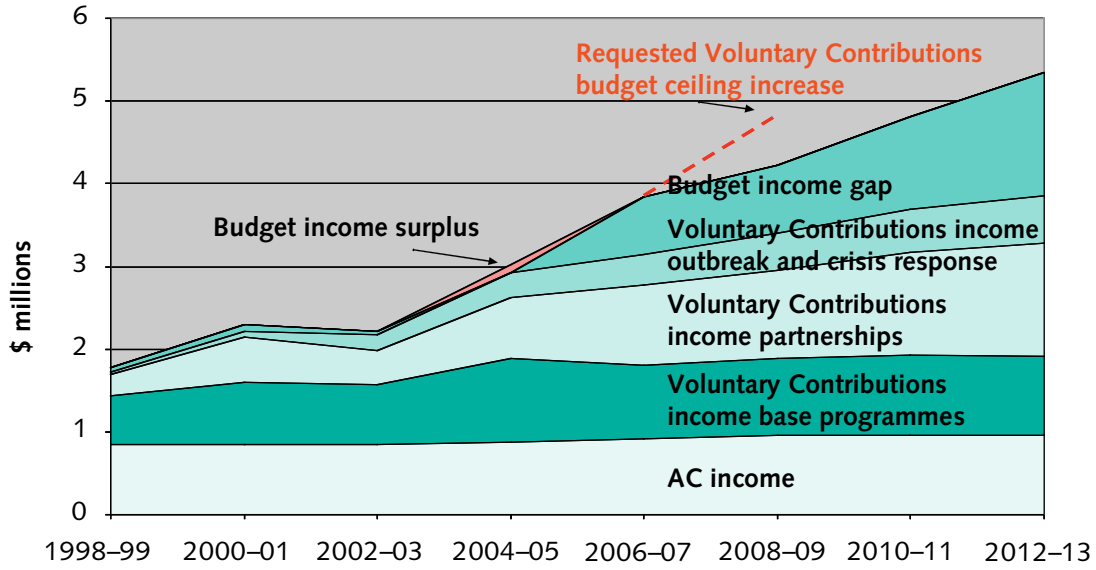


Figure 2 shows the contributions from different member states to WHO for the biennium 2006–07. The UK has been the second largest funder of WHO since 2002 and WHO has been either the first or second largest recipient of UN multilateral funds from the UK, with contributions ranging from 17% to 22% (total £675 million in the period 2002 to 2006).

Figure 2: WHO programme contributions by source, biennium 2006–07

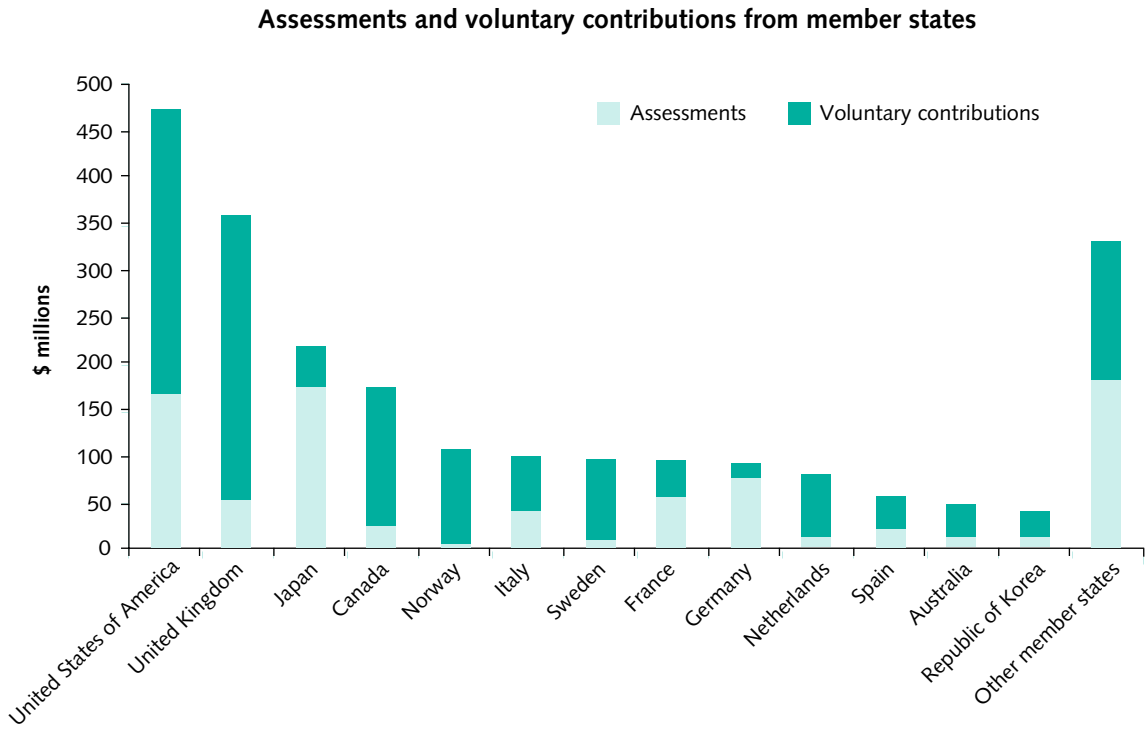
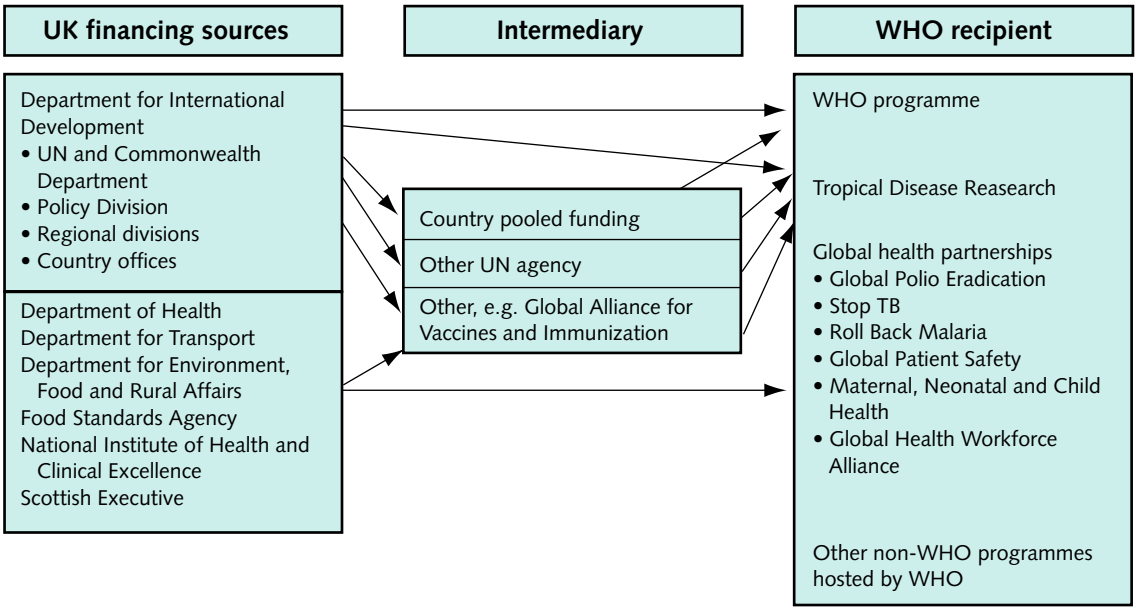


Figure 3 shows that most of the UK's funding to WHO is given as voluntary contributions, and most of this is earmarked for specific activities.

Figure 3: UK WHO programme contributions by type 2002 to 2006

The UK's financing of WHO comes through a variety of different channels and funding arrangements. Figure 4 provides a simplified description of the different financing sources and recipients. Several different departments provide funding to WHO. Nearly 80% of the UK's funding is through DFID. Within DFID, funding may come from a variety of different budget holders, at central, regional and country levels.

Figure 4: Financing flows between the UK and WHO



In addition, the UK funds WHO indirectly through a number of intermediaries. For example, DFID finances pooled funds at the country level, which may in turn fund WHO programme activities within that country (as is the case in Bangladesh). The UK may also fund other UN and global agencies that may have inter-agency arrangements with the WHO. WHO intends to address the fragmentation of its funding from the UK and other large donors through the introduction of a more coherent integrated resource management system.