

DECENTRALIZATION OF ORGANIZATIONS WITHIN THE UNITED NATIONS SYSTEM

PART III: THE WORLD HEALTH ORGANIZATION

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EXECUTIVE SUMMARY

The present report is the last of three volumes on "Decentralization of Organizations within the United Nations System". The first volume focused on "Deconcentration and Managerial Processes" (JIU/REP/92, Part I) and the second on "Comparative Approaches" (JIU/REP/92, Part II). These two volumes emphasized the unique strengths of WHO's decentralized system compared with the organizational structures of other United Nations specialized agencies.

The present volume (Part III) is a more in-depth analysis of the functioning of WHO's decentralized system. Chapter I summarizes some of the past achievements of WHO, its vast potential as a unique global resource in several respects for the international community, and the main policy and structural elements that constitute its value system.

Chapter II tracks the health for all strategy implementation and the performance of WHO's decentralized structures on the basis of: the Inspectors' findings from field visits and discussions with many WHO officials; WHO's internal evaluations of the strategy implementation; the Director-General's reports; a four-country in-depth evaluation of WHO's effectiveness at the country level published in 1991 by the Danish International Development Agency (DANIDA); and the level of external resource mobilization by WHO in support of the strategy. The Chapter concludes that while WHO's decentralized system appears (excellent as described in official documents, its actual functioning has varied from one region to another, but overall it has not been sufficiently efficient and effective in performing the technical co-operation function of WHO under the strategy.

Chapter III reviews the Constitutional provisions bearing on WHO's decentralized mechanisms and processes, including especially the responsibilities and roles of the governing bodies at the global and regional levels, and those of the DirectorGeneral and the Regional Directors, who all share responsibility for optimal use of WHO's resources. The Inspectors find that the management oversight authority of the Executive Board under the Constitution needs to be applied and enforced more effectively and comprehensively throughout WHO, especially in the Executive Board's working relations with the Regional Committees. The Inspectors also urge that the relevant Constitutional Article by which the

Director-General is "the chief technical and administrative officer" of WHO should be applied both in letter and spirit in working relations with the Regional Directors. It is the Inspectors' judgement that the Constitutional clauses relating to WHO's decentralized system are sound, but need to be applied more consistently, faithfully and forcefully.

Chapter IV reviews the overall management of decentralization mechanisms and processes in WHO. It traces resource allocation trends in the past decade among the different geographical levels, analyzes the three-layered structure of the technical programmes and the special status of the global, "vertical" programmes, and discusses some key elements of the health and biomedical information programme and of three support services. The Inspectors find that the generation and dissemination by WHO of valid scientific and technical information needs to be given the recognition and organizational status commensurate with relevant Constitutional provisions. The Inspectors also spotlight a number of serious personnel management problems with significant cost implications for the Member States, and which require the urgent attention of the Executive Board.

A summary of the main recommendations appears in Chapter V. Figures 1 to 8 at the end of the report, which present a graphic picture of WHO's decentralized structure, form an integral and substantive part of the report.

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I. INTRODUCTION

1. The integrated regular and extrabudgetary programme of the World Health Organization for 1992-1993 totals US\$ 1.7 billion. This represents about the largest share for the current biennium among the specialized technical agencies, and accounts for about 20 per cent of the combined budgets of United Nations system organizations. Over and above the arithmetic significance of its budgetary figures, however, WHO can be considered to represent a unique global resource for the international community in several other respects.

2. Firstly, WHO's Constitutional objective is the attainment by all peoples of the highest possible level of health, defined as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Health being the vital prerequisite to the welfare and productivity of individuals, families and communities, WHO is thus entrusted with life and death issues governing all human and community endeavours throughout the world.

3. Secondly, the Organization has demonstrated its universal invaluable role with some significant achievements since its Constitution entered into force in 1948. For example, its mass vaccination campaigns against yaws in the early fifties effectively extended protection to close to 50 million people in the developing countries. Another large-scale campaign from 1967 to 1977 successfully eradicated smallpox from the face of the earth. The Onchocerciasis Control Programme (OCP) has virtually conquered river blindness in West Africa, enabling millions of peasants to regain socially and economically productive lives. The universal childhood immunization programme, conducted jointly with UNICEF, and aimed at vaccine-preventable diseases of childhood such as polio and measles, has expanded protection of infants against these diseases from 5% in 1974 to over 70% today in the developing regions. These successes point to the vast potential of the Organization in its international health work.

4. Furthermore, WHO's Constitution can be considered unique among other organizations' constitutions framed before 1950 in that it assigns equal importance to the normative, co-ordinating and directing role of the Organization on the one hand and to its technical co-operation role on the other. Neither the Constitution nor the Secretariat structure makes programme or budgetary

distinctions between these two mutually reinforcing components of the organization's functions. By hindsight and in comparison with other organizations, the framers of WHO's Constitution displayed a remarkable vision of the organization's purposes and functions.

5. WHO is pioneer in yet another respect: the shift from project-based technical assistance towards support for country health programmes, capacity building and self-reliance in national health development, as far back as 1977. In that year the thirtieth Health Assembly endorsed the Organization's concept of technical co-operation as a process whereby Member States cooperate with their Organization by making use of it to define and achieve their social and health policy objectives, through programmes that have been determined by their needs and that are aimed at promoting their self-reliance for health development. It has taken the rest of the UN development system over ten years to recognize the wisdom of this approach to technical cooperation.

6. The Organization's focus on national programmes is more clearly reflected in its national, regional and global strategies for health for all by the year 2000, based on primary health care. These strategies hardly differ from comprehensive development blueprints, with their emphasis on political commitment and advocacy, social equity, multisectoral and interagency actions, national decentralization processes, community participation and empowerment in the spirit of self-reliance and self-determination. The regional and global strategies are designed to provide optimal support to the countries in the formulation and implementation of health policies, strategies, plans of action and programmes for attaining the goal of health for all (see chapter II).

7. Closely related to the foregoing is WHO'S constitutionally decentralized model, which is the object of this report. This model hinges on the World Health Assembly and the Executive Board at the global level, the regional committees at the regional level and individual Member States at the country level. At this level Member States assume responsibility for implementing policies and programme strategies collectively agreed at the regional and global levels. Responsibility also devolves on individual Member States for the proper use of and accountability for WHO's resource allocations in support of programmes, as well as for programme monitoring and evaluation.

8. The Secretariat structures of the Organization are designed to support Member States at the three levels. WHO currently has six

regional offices: Africa (AFRO); the Americas (AMRO) which is integrated with the Pan-American Health Organization (PAHO); Eastern Mediterranean (EMRO); Europe (EURO); South-East Asia (SEARO) and the Western Pacific (WPRO). There are in addition 92 country offices which together with the six regional offices represent the largest field office network by any specialized agency within the UN system.

9. Decentralization is considered in WHO to be an integral part of the Organization's value system, a necessary condition for its world-wide effectiveness and a prized principle of public health administration. Thus decentralization within WHO also seeks in a way to support the process of decentralization of national health services for the benefit of persons and communities at the intermediate and district levels. Decentralization in addition enables WHO's Member States to identify themselves more closely with the Organization, to adapt collectively-agreed policies and strategies to specific local conditions, and to feed back to WHO information from the 'ground that strengthens its constitutional functions.

10. The foregoing paragraphs suggest the potential of WHO and the significance of its decentralized structure to the full realization of that potential. The functioning of this structure has been periodically reviewed by WHO's governing bodies and Directors-General since 1953¹. If in the course of these reviews the inherent wisdom and value of decentralization have never been subject to doubt, some concerns have nevertheless been raised and debated as to whether the functioning of the Organization's present decentralized structure fostered the most economical and efficient use of its programme, budgetary and staff resources, which are limited relative to the magnitude of needs in the Member States.

11. WHO has endeavoured to address these concerns by strengthening its internal managerial processes as typified by two key internal

¹ Examples include: "Organizational Study on Regionalization" (1953). "Report on the Organizational Structure and Administrative Efficiency of the World Health Organization" (1975). "Organizational Study on the Interrelationships between the Central Technical Services of WHO and Programmes of Direct Assistance to Member States" (1975). "Organizational Study on WHO's Role at the Country level" (1978). "Study of WHO's Structures in the light of its Functions: processes, structures and working relationships" (1980). "Management of WHO's Resources" (1987). "Note by the Director-General on the selection and appointment of the Director-General and the Regional Directors" (1988).

documents, namely "the Managerial Framework for Optimal Use of WHO's Resources in Direct Support of Member States" (1983) and "Guidelines for Preparing a Regional Programme Budget Policy" (1985). These documents spell out the programmatic and managerial issues to be addressed as well as responsibilities and roles at the different geographical levels of the Organization in supporting countries to strengthen their planning and managerial capacities to develop and implement their health for all strategies and programmes and build up their infrastructures.

12. These measures followed the progressive refinement and systematic use of WHO's six-yearly General Programmes of Work, and the introduction of a new process of programme budgeting WHO's resources at the country level - a rolling process of programming by objectives and budgeting by programmes, emphasizing government responsibility and a programme-based approach by WHO. In the same vein, the Director-General also introduced "financial audit in policy and programme terms" which sought to establish the extent to which government/WHO activities comply with and promote the Organization's collective policies.

13. The above measures together represent, on paper, an elaborate managerial control system. However, an internal document submitted to the Executive Board in May 1987 (EB81/PC/WP/2), while noting clear achievements in the consolidation of WHO's value system of policies, strategies, programmes and structures, pointed to significant shortcomings in the field implementation of that value system as well as in the functioning of WHO's system of decentralization.

14. Some of the key issues concern, for example, the depth of commitment by individual Member States to programme policies and managerial principles adopted collectively within the governing bodies; the effectiveness of the Constitutional role of the Regional Committees and of the correlation of that role with the roles of the Executive Board and the World Health Assembly; the potential and instances of management tension between the Director-General and Regional Directors who are all elected by the same Member States, etc.

15. The Executive Board took up some of these issues once again in 1988, notably examining the ways and means of ensuring a greater role for the Director-General in the process of selecting and appointing the Regional Directors, and strengthening their accountability to the Director -General to ensure, as observed by

one Board Member, "that decentralization did not result in the disintegration of the Organization".

16. While some Board members took the view that decentralization in WHO had stood the test of time, that its strengths and benefits far outweighed its recognized constraints, and that controversy stemmed from a lingering sense of hierarchical personal relationships, for his part the Director-General recalled that decentralization had been pursued in the preceding decade to the limits of what was constitutionally possible, and that there had been a lot of inefficient use of resources. He observed that WHO was the only specialized agency with a "geopolitical regional system" and its governing bodies had to keep a constant watch on how the best value could be obtained from its resources. The Director-General further expressed the view that "if Member States were sincerely, courageously, and honestly to make use of WHO's resources in the manner determined by the Health Assembly and the Board, he was certain that at least five times more extrabudgetary resources could be mobilized than at present."²

17. The Inspectors note that close to forty years of reviews, discussions, and sometimes passionate debates in the governing bodies of WHO concerning its decentralized structure have yielded few significant changes to the managerial mechanisms of decentralization as conceived and applied since the organization's inception. This fact by itself is testimony to the abiding strength inherent in WHO's Constitution and decentralized system.

18. On the other hand, the practical operation of this system has been recognized in several internal documents and audits to constrain the overall effectiveness of the Organization. In WHO, more than in any other organization of the common system, ineffective management is best equated to the number of persons and families which could have been saved from disease and death had resources been used to optimal advantage. In this light any management mediocrity in WHO inevitably carries life and death implications more than in other organizations. This simple fact invokes the moral responsibility of WHO's Member States, governing bodies and executive leadership which share management responsibility for the organization and its collective resources.

² Executive Board, Eighty-First session, 1988 (Summary Records).

19. The present report should be seen in that context. It is designed to assist the governing bodies and the executive management in their re-assessment of decentralization in WHO with emphasis on possible changes that would close some management loopholes, effect economies, further strengthen internal controls and make WHO more effective than the sum of its parts. The Inspectors are of the view that since WHO has already effectively achieved decentralization as part and parcel of its value system and as a sound strategic principle of management, its governing bodies and executive leadership should henceforth use decentralization as a flexible, pragmatic management tool to guarantee that resources are indeed used to advance the Organization's policies and strategies for the benefit of its global constituency.

20. In conducting this study as part of a system-wide report on "Decentralization of Organizations within the United Nations System" Parts I and II (JIU/REP/92/6), one of the Inspectors held extensive discussions with high-level officials in WHO/HQ, reviewed numerous internal WHO documents relevant to the study, visited the WHO Regional Office for the Western Pacific in Manila as well as some countries in that region, and had in-depth discussions in Geneva with the WHO Regional Director for Africa together with the Director of the Support Programme (DSP/AFRO). The Inspectors record their heartfelt appreciation to all those who volunteered opinions, suggestions and help to make WHO even more dynamic and useful to humankind in the decades ahead. Except where specified otherwise the tables and figures in this report are based on data provided by WHO or sourced from WHO documents.

II. HEALTH FOR ALL STRATEGY

A. Roles and functions of the Secretariat

21. In 1977 the World Health Assembly decided (resolution WHA30.43) that "the main social target of governments and WHO in the coming decades should be the attainment by all the citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life". This resolution certainly marked the beginning of a new era in WHO's international health work, for it set in motion significant developments whose impact has endured till today within the Organization.

22. One such development was the initiation in 1978 of an extensive review of "WHO's structures in the light of its functions: WHO's processes, structures and working relationships". In the words of the Director-General, this study constituted "a managerial review of unprecedented magnitude, dealing as it does with the way the Organization acts and reacts at all policy and operational levels". The conclusion of this study in 1978 coincided with yet another momentous development: the adoption by the World Health Assembly of the report of the International Conference on Primary Health Care including the Declaration of Alma-Ata, and the concomitant launching of the "Global Strategy for Health for All by the year 2000" based on primary health care (WHA32.30).

23. This development was followed by the formulation of national and regional strategies for attaining the goal of health for all by the year 2000. As stated by the Director-General in 1979, "the main thrust of the organization's activities over the coming decades will be to support national, regional and global strategies for attaining health for all by the year 2000" (EB/65/18). Successive resolutions of the Health Assembly and the Executive Board have directed the WHO Secretariat to develop and organize programmes and allocate resources to reflect the organization's overriding commitment to the implementation of the health for all strategy at the country, regional and global levels.

24. This strategy has thus assumed overwhelming importance for WHO since 1979. It has shaped the Organization's global outlook and harnessed its resources and energies to the challenge of health for all on a scale probably unparalleled by any other global strategy within the UN system. The extent to which this strategy has been

implemented in the last decade may therefore afford an appropriate yardstick by which to assess WHO's overall performance and, by extension, the effectiveness of its decentralized, operational structures.

25. As the main pillars of WHO's decentralized system, individual Member States assume primary responsibility for the formulation, implementation, monitoring and evaluation of their health for all strategies collectively endorsed by the governing bodies. The supportive role of the WHO Secretariat is, however, clearly specified in several WHO documents, notably in the health for all series and six-yearly general programmes of work.

26. At the country level, for example, WHO is required, amongst other things to:

- (a) Collaborate, at the request of the governments concerned, in the formulation of national policies, strategies and plans of action;
- (b) collaborate with other UN agencies and bodies in support of national efforts for health and socioeconomic development;
- (c) assist in setting in motion the country health programming process, participating in its implementation and strengthening of national health information systems;
- (d) provide continuing support, on request, to countries' programme priorities falling within WHO's general programmes of work;
- (e) support, on request, the design of health systems based on primary health care, health manpower development, the development and application of appropriate technology, etc.

27. The regional offices are expected, inter-alia, to:

- (a) Support the work of the Regional Committees, give effect to their decisions and carry out those aspects of the regional strategies assigned to them by the Regional Committees;

- (b) provide the Regional Committees with information required to formulate, implement, monitor and evaluate the regional strategies, and ensure the exchange of relevant information among countries in the regions;
- (c) support countries in developing and applying programmes of technical co-operation among themselves (TCDC) and assist in establishing and sustaining regional networks of national centres for health development;
- (d) promote and carry out direct technical co-operation between WHO and Member States at the request of the governments concerned;
- (e) service regional committee bodies and mechanisms involved in developing the regional strategies, and serve as practical links with relevant regional socioeconomic bodies of the UN system.

28. Headquarters is required, inter-alia, to it:

- (a) Support the work of the Health Assembly and the Executive Board, give effect to their directives and carry out those aspects of the global strategy assigned to;
- (b) ensure the availability and dissemination of relevant and valid information in support of the strategy;
- (c) ensure the preparation of guidelines required in all regions, such as for the managerial process for health programme development, the selection and use of indicators for monitoring and evaluation, the integration of a variety of programmes into primary health care, etc;
- (d) service the various global bodies and mechanisms involved in developing the global strategy, and constitute a practical link with the relevant global social and economic bodies within and outside the UN system; etc.³

³ The Secretariat functions at the three geographical levels are summarized from the Health for All Series No. 2: Formulating health for all strategies by the year 2000.

29. In addition to the above specification of roles and functions to be performed at all levels, the Seventh and Eighth General Programmes of Work respectively for the periods 1984-1988 and 1990-1995 define the broad principles guiding the various programmes, activities, services and functions developed by WHO to support the health for all strategy implementation. Also defined are sets of criteria for the selection of programme areas for WHO involvement, for determining the organizational level(s) for implementation of programme activities, and for the allocation of resources to programme activities.

30. The criteria which determine the organizational level(s) for programme implementation are of special relevance to the subject of this report as they indicate how WHO's decentralized structure is conceived to function in practice. These criteria are therefore reproduced below as stated in the Seventh and Eighth General Programmes of Work:

- (a) Country activities are indicated if: they aim at solving problems of major public health importance in the country concerned, particularly those of underprivileged and high-risk populations; they result from a rational identification by countries of their priority needs through an appropriate managerial process; they are likely to give rise to the establishment and sustained implementation of countrywide health programmes;
- (b) intercountry and regional activities are indicated if: similar needs have been identified by a number of countries in the same region following a rational process of programming or a common awareness of joint problems; the pursuit of the activity as a cooperative effort of a number of countries in the same region is likely to contribute significantly to attaining the programme objective; for reasons of economy the intercountry framework is useful for pooling selected national resources, e.g., for the provision of highly skilled technical services to countries; the cooperating countries, whether developing countries cooperating among themselves (TCDC/ECDC), developed countries doing so, or developed countries cooperating with developing countries, have requested WHO to facilitate such cooperation; the activity encompasses regional planning, management and evaluation or is required for regional coordination; or

the activity is an essential regional component of an interregional or global activity;

- (c) interregional and global activities are indicated if: similar requirements have been identified by a number of countries in different regions following a rational process of programming or a common awareness of joint problems; the activity consists of facilitating or supporting technical cooperation among countries in different regions, and its pursuit is likely to contribute significantly to attaining the programme objectives; for reasons of economy the interregional framework is useful for pooling selected resources, e.g., for the provision of highly specialized and scarce advisory services to regions; the activity encompasses global planning, management and evaluation; the activity is required for global health coordination and for central coordination with other international agencies.

31. The foregoing paragraphs are only a very concise summary of the commendable work done by WHO to elaborate in different policy documents the roles and functions of the different secretariat levels in promoting and supporting at the request of governments the implementation of the health for all strategy. The following section assesses the extent to which this conceptual and organizational framework has been implemented in the past decade.

B. Performance assessment

32. Strategy evaluations: WHO has conducted to date two extensive global evaluations of the implementation of the health for all strategy. The first evaluation, contained in the Seventh Report on the World Health Situation (1987), covers the first five-year period of the strategy (1978-1984). The second evaluation, published as the Eighth Report on the World Health Situation (1992), covers the period 1985-1990. Both evaluations derive principally from national and regional evaluation reports. The high governments' response rates of 89% for the first evaluation, and 96% for the second, suggest the solid political commitment of Member States to the strategy and goal of health for all by the year 2000. It is to be pointed out that no comprehensive evaluation of WHO's technical and operational support to the strategy implementation has yet been undertaken since the strategy was adopted in 1979. The Inspectors recommend that such evaluation be initiated.

33. The first evaluation, while noting major differences in progress between the developed and developing regions and even among the latter, pointed to several general achievements, such as in growing public awareness about health issues, the production of health manpower or the large increase in immunization coverage. It also indicated some general constraints affecting strategy implementation in the majority of developing countries, including, among others: weak information support for the managerial process at the country level; inadequate national capabilities and mechanisms to support policy formulation and for the continuous monitoring and evaluation of national health for all strategies; inadequate involvement of other development partners and NGOs especially in the implementation process; limited mobilization of internal and external resources and declining proportion in real terms of national resources devoted to the health sector, etc.

34. The second evaluation report noted the persistence of the above constraints, but also indicated highly varying degrees of progress among regions, countries and, in some cases, population groups within countries. Overall, however, the world health situation in 1990 appeared to have improved compared to the period covered by the first evaluation (1978-1984). Some examples, amongst others, of progress reported in the second evaluation include: the near universal endorsement of the global strategy for health for all; improvements in life expectancy and mortality rates; expanding population coverage by the eight essential elements of primary health care; increased expenditure for health as a percentage of central government spending, although such expenditure in many developing countries tended to decline when adjusted to inflation and demographic rates and regressive economic indicators.

35. The fact that virtually all Member States of WHO are reported to be committed to the health for all strategy must be credited to the global directing, co-ordinating and normative functions of the Organization and its close relationship with its constituency. As regards its technical co-operation role, however, the evaluation findings suggest more challenges than successes. It is evident from the information and charts in the second evaluation report for example that progress in strategy implementation and health status globally is conditioned more by Member States' overall socio-economic performance and level of development than by WHO's performance of its technical cooperation role, which has never been evaluated. The evaluation reports essentially record and synthesize

results and data reported to WHO by the Member States on their activities within the framework of the strategy.

36. To obtain an objective picture of WHO's technical cooperation role, the Inspectors have relied on several sources of information within and outside WHO and the UN system. In March 1992 one of the Inspectors visited the WHO Region of the Western Pacific (WPRO) and observed the excellent work being done by the regional and country offices to advance the goals of WHO in general and the health for all strategy implementation in particular, despite some staffing constraints. Collaboration between the regional office and headquarters appeared to be smooth overall, but some problems of co-ordination were noted with some programmes delivered directly from headquarters. A notable example was the Mother and Childhood and Family Planning Programme whose separate headquarters units appeared to operate independently of one another in supporting regional and country activities.

37. Discussions with officials of the WHO Regional Office for Africa (AFRO) revealed that the office has taken the following significant steps since 1985 to strengthen its technical support to countries of the region: establishment of three subregional health development teams and subsequently of WHO country health support teams staffed by associate experts and local personnel recruited under special services agreements, increased emphasis on decentralization of health services to the district level, or the establishment at the regional office of a central monitoring unit to track implementation of the health for all strategy. Problems of co-ordination with some headquarters programmes were also raised, mainly because of their limited or uneven decentralization of functions and resources to the operational level.

38. While other WHO regional offices are reported to be very much in the frontline of the strategy implementation, these discrete positive findings do not, however, add up to a solid universal achievement that could be credited directly to WHO's technical co-operation role, save perhaps for the expanding immunization coverage for which, however, much of the credit for field-level successes could be attributed to UNICEF, which spins the operational wheels of the programme.

39. Moreover, when the findings of the second evaluation are reviewed against the 1989 targets of the Seventh General Programme of Work of WHO, which was the very first prepared specifically to represent WHO's unified support to the strategy implementation, and

which covers roughly the same period (1984-1989) as the second evaluation (1985-1990), it becomes obvious that the implementation of that Programme generally fell below target in many developing countries, particularly the least developed among them. This is especially true for programmes listed under the health system infrastructure and disease prevention and control. Probably for this reason the Eighth General Programme of Work (1990-1995) contains basically the same programme narratives as the seventh and simply shifts the goalposts from 1989 to 1995.

40. In sharp contrast to WHO's celebrated achievements of its early years and mid-seventies, the second strategy evaluation draws the following disturbing epidemiological trends, which reflect negatively on WHO's technical co-operation role: "Tropical diseases seem to have gone on a rampage, with cholera spreading to the Americas for the first time this century, yellow fever and dengue epidemics affecting even greater numbers, the malaria situation deteriorating, schistosomiasis establishing itself in new areas, and leishmaniasis and non-venereal endemic syphilis increasing. The AIDS pandemic is spreading globally, as also are genital herpes and sexually transmitted chlamydial disease. Pulmonary tuberculosis is on the increase, partly stimulated by HIV co-infection. Pneumonia and hepatitis B remain serious threats. The whole category of chronic noncommunicable diseases is increasing, especially in the developing world, where the number of cancer cases has overtaken that in the developed countries. Lung cancer has overtaken breast cancer as the leading cancer in females in some developed countries owing to the spread of the smoking epidemic among women. Diabetes is increasing everywhere, blindness (especially cataract) is more common, alcohol-related diseases are up (especially in developing countries), as are mental problems and suicide (particularly in the developed countries)".

41. Although the world health situation is influenced by many factors, and more specifically by the socio-economic situations of the Member States, which lie beyond the direct control of WHO, no other organization within or outside the UN system has direct responsibility for world health. The question that may therefore be asked is whether the full potential of WHO is being brought to bear on the alarming health challenge indicated in the above paragraph. The answer to that question, based on available evidence, is certainly negative.

42. The transition from concepts and policies to practice and results has not been uniform throughout WHO. Neither the functions and criteria listed in paragraphs 26-30 above for the different WHO Secretariat levels, nor the provisions of some managerial tools devised to ensure effective support to the countries (e.g. Regional Programme Budget Policy and Managerial Framework for Optimal Use of Resources) are being applied effectively and uniformly. How to harmonize the work of headquarters-based programmes with regional and country programmes has become problematic. More serious still, the key issues identified in the 1979 internal report on "WHO's structures in the light of its functions" have remained largely unresolved.

43. **The Director-General's assessment:** In the above-mentioned 1979 report, the Director-General had noted "the widening gap that has grown between policy and practice in WHO, linked closely to the question of centralism versus decentralism". In his words, "the central organs of WHO have become nominally stronger, but have little control over the bulk of the Organization's activities, namely those that take place in the regions and countries. The regional structures, too, have become stronger and more independent, yet have tended to concentrate on intercountry activities and have little control over the Organization's activities in countries and little influence in shaping overall policy". The report did propose wide-ranging measures to ensure that activities at the different secretariat levels promoted integrated action in support of the strategy implementation; WHO's role at the country level was to be significantly enhanced; staff composition and profiles in the regional offices and headquarters were to be altered in the light of the strategy requirements; there was to be increased generation and dissemination by WHO of valid and appropriate scientific and technical information; the work of the regional committees was to be more business-oriented and focused on operational priority issues within the regions; etc.

44. Seven years later, in his introduction to the 1986-1987 programme budget, the Director-General observed that WHO's "technical co-operation role has not yet matched up to its co-ordinating role. It still does not reflect adequately the organization's collective policies. Far too many activities in countries are of doubtful relevance to genuine strategies for health for all, and of those that are relevant too few are adequate to have a lasting influence. This is all the sadder when one reflects that the need to support the mainstream of national health

activities (emphasis added) rather than separate WHO projects has been WHO's declared policy for more than a decade".

45. Furthermore, a 1987 working paper entitled "Management of WHO's Resources", submitted by the Director-General to the Executive Board (EB81/PC/WP/2), elaborated even more bluntly on the weaknesses in the functioning of WHO's decentralized system in support of the health for all strategy implementation. Some common problems identified included: weak staffing of WHO country offices and their inability to carry out the functions devolving to them under the strategy; inadequate concentration of some regional offices on the management of technical cooperation and limited delegation of authority to the country level; inappropriate staff profiles in the regional offices and lack of the right balance between expertise that should be deployed at headquarters and in the regions; inadequate dissemination of valid information to the countries; shortcomings in fellowships awards and purchases of supplies and equipment which account for a significant share of WHO's resources; etc.

46. Probably recognizing his inability to correct these shortcomings within the regions, the Director-General launched in 1989 a "new strategy of intensified co-operation with countries and peoples in greatest need", under which all existing resources would be focused into coherent and co-ordinated action, country by country, through all WHO's programmes and at all levels of the Organization, in the context of existing and potential resources of international co-operation. The Inspectors applaud this initiative, for it seeks to address a long-standing strategic weakness in WHO's decentralization policy and practice, which indiscriminately assumed, wrongly, that all countries, irrespective of their level of development and technological endowment, could uniformly implement the health for all strategy, without WHO's special supportive or affirmative action.

47. At the same time, the Inspectors note that barely 20 countries "in greatest need" have so far been covered by this new strategy" and that, although the strategy is referred to as "new" its concept, substance and thrust are, in fact, the same requirements and approaches prescribed for WHO support to all countries in the context of the health for all strategy, as described in the health for all series, the Seventh and Eighth General Programmes of Work, the Regional Programme Budget Policy and the Managerial Framework for Optimal Use of WHO's Resources in Direct Support of Member States. Thus the launching by headquarters of this commendable but

somewhat parallel "new strategy" could be construed as veiled recognition of the inability of some WHO's decentralized structures to meet the obvious and pressing technical co-operation needs of the least developed countries within their regions.

48. **A 1991 DANIDA Report**⁴ evaluating WHO's activities and effectiveness in Kenya, Nepal, Sudan and Thailand confirmed the patently weak analytical capacity of WHO in the four countries, some difficulties of integrating headquarters-delivered programmes into the mainstream of national programmes, lack of a system of WHO priorities in the countries, the undue concentration of WHO's management powers and resources at the regional level, "leaving no scope for an effectively functioning country office". The report observes that in three cases, the "country office is left entirely outside the process of programme implementation, which is dealt with per "long-distance" through either the regional office in the case of country and regional programmes /projects or through headquarters in the case of global programmes. In this vacuum of remote controlled WHO cooperation, the country representative often finds it difficult to acquire an overview of the number, volume and contents of ongoing WHO activities at the country level. This was documented too well to the Study Team, especially in Kenya where it was almost impossible to get data from WHO's country office on the organization's country-level activities".

49. The report further notes that in three cases the role of WHO in the area of primary health care "was found to be very limited, with other donors being lead agencies in relation to both field programmes and government policy advice. The marginal role of WHO in relation to other donors was even found within traditional WHO programmes like expanded programme on immunization in Nepal and Sudan, where UNICEF was the programme "carrying" donor in terms of both financial support and technical assistance to programme implementation".

50. On the key issue of staff and expert profiles, the report observes that, in its recruitment policies, WHO has not yet realized that the level of local medical know-how has improved dramatically, even in a poor country like Nepal where "both government and senior health staff confirmed that the major gaps were not found in relation to medical know-how, but rather within institutional and health management capacity".

⁴ Effectiveness of Multilateral Agencies at Country Level: WHO in Kenya, Nepal, Sudan and Thailand, DANIDA, 1991.

51. The DANIDA report concludes that "from a structural point of view, WHO's set-up with representation and division of responsibilities between a country office, a regional office and the headquarters looks ideal. A country representation, supported by technical backstopping at a specialized regional level and global programmes based on international health research disseminated through this structure from the headquarters to the national level, gives the impression of a strong and functional institutional structure. However, the four country case-studies seem to indicate that WHO has not been able to utilize the advantages of this institutional set-up, mainly due to a non-functional division of work (in terms of both formal competence and professional resources) between the three organizational levels. More specifically, the following factors have been obstacles for an effective functioning of the threelevel organisational structure.

- A centralized management structure with a focus at the regional level.
- A politicized regional level.
- A country office left with mainly diplomatic and some administrative tasks.
- Insufficient professional capacity allocated to the country level.
- Competition for resources between the global level and the regional/country level programmes".

52. The findings of the DANIDA report aptly underscore the fact that WHO's decentralized structure is not functioning in practice as described in policy documents (see paras. 26-30 above), and that the "gulf between policy and practice" noted by the Director-General in 1979 continues to bedevil the Organization more than a decade later, notwithstanding resolutions of the Health Assembly since 1979 calling for technical and administrative measures required to support Member States in the formulation and implementation of their national health for all strategies (see, for example, WHA32.20, 33.24, 34.36, 35.23, 35.24, 34.37, etc.).

53. The mobilization of external resources in support of the strategy is one of the major priorities assigned by the Health Assembly to the WHO Secretariat. The WHO 1992-1993 integrated programme budget figures suggest that the Organization as a whole has been quite successful in attracting extrabudgetary resources, estimated in the current biennium at US\$ 930 million or US\$ 166 million (22%) in excess of the regular budget. These figures

include only resources channelled directly through WHO programmes. The Inspectors were unable to obtain from WHO accurate figures of the proportion of extrabudgetary resources that were mobilized by and for regional and country programmes.

54. Figure 1 (in the annex for all figures) which estimates resources for 1994-1995 by organizational entity, shows significant concentration of extrabudgetary resources at global and interregional levels and uniformly very little in the regional offices, save for PAHO. As the main technical cooperation structures of WHO, these offices should ideally be in the forefront of resource mobilization for intercountry and country programmes. But the Inspectors' findings, confirmed by the data in figure 1, suggest otherwise. The country resource mobilization and utilization exercises conducted in some regions have had only mixed results. Most donors prefer to deal directly with recipient government agencies, prudently bypassing WHO's regional and country structures. The same donors, however, show a predilection for channelling resources through headquartersbased technical co-operation programmes - known as "vertical programmes" in WHO terminology.

55. It would appear that WHO's financial regulations and rules are subject to interpretation on the scope given to the regional and country offices to mobilize, manage and account for extrabudgetary resources in the same way as headquarters-based programmes. If that is the case then the relevant rules need to be clarified and updated in keeping, particularly, with Health Assembly resolution 34.37 (1981) and subsequent ones which call for the mobilization of external resources for the strategy implementation.

56. As of present, however, the marginal role played by WHO's field-based technical co-operation structures in resource mobilization, coupled with the concentration at headquarters of extrabudgetary resources for technical co-operation, would seem to strengthen the impression that WHO's decentralized system is perceived by the donor community, as much as by WHO headquarters itself, as malfunctioning to the point of a fiducial, credibility crisis. This conclusion echoes a similar conclusion by the Director-General in 1988 when he took the view, at the eighty-first session of the Executive Board, that if WHO's unique "geopolitical regional system" of decentralization had been perceived to function efficiently and effectively in the manner determined by the Health Assembly and the Board, "he was certain that at least five times more extrabudgetary resources could be mobilized than at present".

57. Having reviewed in the foregoing paragraphs the overall functioning and performance of WHO's decentralized system in support of the health for all strategy, the Inspectors conclude that, while the three-layer organizational structure appears excellent as described in the Constitution and official documents, its actual functioning is beset by serious and complex problems of a constitutional, political, managerial and programmatic nature. The Inspectors caution that there are differences - significant in some cases - in the operational performance of the six regional offices and headquarters programmes. It is also recognized that some major external factors such as the international debt burden, recessionary economic environment, dwindling terms of trade for the developing countries, natural and man-made disasters, etc., adversely affect the technical co-operation setting of WHO and other UN system organizations.

58. Notwithstanding these challenges, the Inspectors believe that WHO has rendered some appreciable services to its Member States, especially to the developing countries. Its vast potential can, however, be realized to its optimal pitch if its governing bodies introduce the courageous reforms necessary to enable their Organization to intensify implementation of its value system and the health for all strategy to which significant resources and energies have been committed in the last decade. In this light and against the backdrop of the findings in this chapter, the Inspectors review in the following two chapters more specific issues requiring the urgent attention of the Executive Board and the Health Assembly.

III. CONSTITUTIONAL FRAMEWORK

59. The provisions in WHO's Constitution having a direct bearing on the Organization's decentralized mechanisms and processes relate to the Health Assembly, the Executive Board, the Regional Committees, the Director-General,⁵ the Regional Directors⁵ and geographical areas. These are reviewed below.

A. Governing bodies

60. While the Constitution clearly states the respective functions of the Assembly, the Board and the Regional Committees, it leaves room for interpretation regarding the nature of relations between the Regional Committees on the one hand and the Board and Assembly on the other. By articles 9 and 24-29, the Board's authority, subject only to that of the Assembly, includes management oversight throughout WHO. There is, however, a tendency in some regions to view the Board's authority as being limited only to headquarters, with hardly any influence over the Regional Committees and, by extension, over the regional offices. By this perception, the Board would appear like headquarters own "regional committee", shorn of the high political profile of the real Regional Committees, since the Board is, strictu sensu, a non-political organ. The Inspectors' investigation leaves no doubt that a good many of the problems identified in the preceding chapter can be resolved if the Board exercised fully and effectively its management oversight authority under the Constitution. The Inspectors therefore recommend that the Board should take all the necessary steps to revitalize its management oversight functions throughout WHO. To that end the Board may wish to consider, among other measures, the feasibility of constituting from among its membership, and for a short period which can be extended, an administrative and budgetary watchdog with a small standing secretariat, similar to the UN Advisory Committee on Administrative and Budgetary Questions (ACABQ). It may also be useful to have some Board members who are experts in management and budgetary questions.

61. The Regional Committees, unlike the Board, have an unrestricted regional membership. The Constitution stipulates that the "Regional Committees shall be composed of representatives of

⁵ The Director-General and Regional Director designations used throughout this report refer only to positions and not to the individuals occupying these positions.

the Member States and Associate Members in the region concerned", but does not specify the qualifications and level of such representatives. Should they be Ministers of Health, their technical advisers, and/or directors of medical/health services?. At present the Regional Committees are composed in general of Ministers of Health and their advisers, that is basically the same delegations to the Health Assembly. The Regional Committees thus tend to function in practice as "Regional Health Assemblies", meeting annually like the Health Assembly and discussing virtually the same items on the agendas of the Health Assembly. Overall, moreover, the Committees have very little direct and effective control over the management and operations of the regional offices, leaving the Regional Directors with considerably more scope for independent action than is enjoyed by the Director-General: "the chief technical and administrative officer" of the Organization.

62. The Inspectors see a need for a more structured working and reporting relationship between the Regional Committees on the one hand and the Board on the other. Discussions with many WHO officials and extensive review of internal documents suggest that WHO should progressively concentrate its energies and resources on implementation of the policies and strategies it has commendably elaborated in the past decade and which have been endorsed by all Member States. Since the regional structures are the implementing arms, it would stand to reason that the Regional Committees should increasingly focus on technical, operational and evaluation issues within the context of regional health for all strategies. Such a shift of focus is made all the more essential by the rapidly deteriorating health and socio-economic status of many developing Member States, and by the evidence marshalled in the preceding chapter.

63. If the proposed shift of emphasis is considered acceptable, the next logical move would be to review the qualifications and level of representatives to the Regional Committees to ensure that they are more technically-oriented than politically-oriented. Moreover, health specialists as representatives to the Regional Committees would be less affected by frequent changes of governments and Ministers of Health, which have adverse effects on the continuity of WHO policy implementation. The political and policy-determination functions of the organization would be left to the Health Assembly, further solidifying the unity of purpose of WHO and the Regional Committees could where necessary continue to meet at Ministerial level during the annual sessions of the Health Assembly.

64. Another related issue concerns the frequency of meetings of the Regional Committees. The Constitution stipulates that they "shall meet as often as necessary". Their present annual meetings absorb a considerable amount of the time of regional officers in the preparation of documentation, when they should be concentrating on supporting field activities. Consideration should therefore be given to spacing out Regional Committee meetings once every two years, ideally to coincide with programme-budget years. Estimated financial benefits would exceed US\$ 2 million per biennium if this proposal is implemented.

65. In the light of the foregoing paragraphs the Inspectors recommend that WHO should consider the following changes with respect to its Regional Committees:

- (a) The level and qualifications of representatives to the Regional Committees should be reviewed and very clearly defined below Ministerial level to reflect the proposed change of emphasis and the need for continuity of policy implementation in the Member States of each region. Ministerial level meetings of the Committees could, if necessary, continue to be held during annual sessions of the Health Assembly;
- (b) a more structured authority and working relationship should be instituted between the Regional Committees and the Board;
- (c) they should shift the emphasis of their work to technical and operational issues relating to the implementation and evaluation of regional strategies for health for all;
- (d) The Regional Committees should meet every two years, preferably during programme budget years, to ensure optimal use of resources.

B. Director-General and Regional Directors

66. Professional relations between the Director-General (DG) and the Regional Directors (RDs) are probably the most sensitive node in WHO's decentralized system; mainly because they are all elected officials under present practice. By the terms of the Constitution, the DG is appointed by the Health Assembly upon the nomination of the Board. This Constitutional provision has so far been applied

consistently in practice. The Constitution also provides that the RDs shall be appointed by the Board in agreement with the Regional Committees. In practice, however, the RDs are elected by secret ballot by the respective Regional Committees and endorsed by the Board. Thus the Constitutional provision relating to the appointment of RDs is not strictly observed in practice.

67. The Board could not arrive at a satisfactory solution when it debated this issue at length at its eighty-first session in 1988. The Inspectors are unable to share the opinion of some Board members who took the position that WHO could continue to live with the present situation without undue prejudice to its effectiveness, management integrity and optimal use of resources. The Inspectors believe that Article 31 which makes the DG the "chief technical and administrative officer of the organization" should be fully upheld and made to prevail over other considerations, in order better to reinforce the practical application of Article 45 under which "each regional organization shall be an integral part of the Organization".

68. There is no doubt that WHO has had excellent Directors-General and Regional Directors since its inception, as attested by some of the Organization's achievements mentioned in Chapter I. The Inspectors also have first-hand information about the efficient management of some regional programmes. This very positive record has, however, depended more on individual managerial talents than on foolproof organization-wide checks and balances.

69. Such checks and balances may prove difficult to institute in relations between headquarters and the regional organizations mainly because the present practice of appointing the RDs creates room for the following weaknesses:

- (a) The independence of RDs vis-à-vis the DG, with the consequent exacerbation of underlying centrifugal forces within the Organization;
- (b) some RDs might tend to view their status and role in political rather than in technical terms, with the consequent undue politicisation of an organization which should prize technical pre-eminence;
- (c) possible political debts owed by the RDs to their electors and which cannot be paid without some prejudice to the

integrity of the Organization's policies, regulations and rules;

- (d) likely diversion of resources and time from health advocacy and leadership to the search for electoral support;
- (e) some RDs might be tempted to consider themselves more as servants of their regional electorates than as servants of the Organization as a whole within their respective regions;
- (f) the absence of a structured working relationship between the RDs and other ungraded officials in headquarters who are directly appointed by the DG, especially the Deputy DG.

70. These weaknesses would obviously not be conducive to optimal use of resources, and could, without built-in controls, ultimately jeopardize WHO's otherwise excellent model of decentralization, and impair the effectiveness of its technical co-operation role. There is ample evidence available to the Inspectors to indicate that such is already the case in some regions. The contention that untidy management and political debts could also exist in headquarters as much as in the field is entirely valid. But that risk need not be multiplied by six simply because it exists in headquarters. The Inspectors entertain no illusions about the strong and varied interests at work within the Secretariat and elsewhere to resist any modification of the present system. But the loopholes identified above, the list of which is not exhaustive, cannot be ignored for too long without exposing WHO to an uneven pattern of management at a time of unprecedented world-wide challenges to its capacity to deliver. Organization-wide accountability is more easily exercised when centred on a single, pyramidal executive head rather than on seven as at present within WHO, a situation which, to the best of the Inspectors' knowledge, does not exist in any other intergovernmental or private organization.

71. It may be recalled that within the UN system only the International Telecommunication Union has several elective secretariat positions like in WHO. Unlike WHO, however, ITU has an essentially centralized system of management, which significantly reduces the potential for management tension and conflict among its elected officers. In the UN Secretariat, whose decentralized structures and programmes are comparable with WHO's decentralized

system, the Secretary-General appoints all his twenty or so high-level collaborators following consultations with Member States, which leaves no doubt about the integrity of the chain of command and the ultimate accountability of the Secretary-General for the performance of his appointees.

72. While it must be recognized that the Constitution of WHO sets it apart from other organizations of the UN system, the Inspectors believe nevertheless that the present practice of appointing the RDs can be improved without the need for a constitutional amendment. The first cardinal prerequisite is that the Board must satisfy itself by consensus that persons nominated for the DG position meet the full spectrum of qualifications required for that position. If that prerequisite is fulfilled the Board should consider it reasonable to empower the DG to select and nominate the RDs. The following measures are therefore recommended:

- (a) The Director-General should be empowered to select and nominate RDs for confirmation by the Executive Board, following consultations and in agreement with the regional committees concerned or their Bureaux;
- (b) the selection and consultation processes should be handled confidentially by the DG to preclude any open competition for the RD position;
- (c) if, as recommended earlier, the qualifications and level of Regional Committee representatives are altered to emphasize concern for implementation issues, such a change, combined with the new method proposed above for selecting RDs, would require them to become technical managers in a more conventional sense, i.e. fully involved, non-political, hands-on managers of their regional programmes, a role very similar to that now performed in the regional offices by the Director of Programme Management (DPM). This position could consequently become duplicative, if not redundant, and might therefore be abolished. If applied to all six regional offices, the proposed measures would yield estimated savings upwards of US\$ 1.7 million each biennium, which may be judiciously used, for example, to strengthen WHO's presence in the least developed countries;

- (d) the term of office for all RDs, including the RD for AMRO/PAHO, should be five years, renewable once. This recommendation could also apply to the term of office of the DG;
- (e) the RD post description should be modified to allow for substantial decentralization of some of their authority and functions to WHO Country Representatives in country programme management, administration and resource mobilization;
- (f) whether or not these proposals justify a review of the grading of RD positions is left to the discretion and wisdom of the Board.

73. If implemented, the above recommendations should considerably strengthen WHO's management integrity, unity of purpose and action and the productive use of scarce resources. Indeed, the proposed changes could facilitate more decentralization of functions and resources from headquarters to the regions and probably raise the level of mobilization of extrabudgetary resources in support of inter-country and country programmes. These likely benefits consequently justify a careful study by the Executive Board of the Inspectors' recommendations.

C. Regions and regional organizations

74. Under article 44 of the Constitution, the Assembly "shall from time to time define the geographical areas in which it is desirable to establish a regional organization". Currently the Americas are covered by one regional organization, (AMRO/PAHO) Asia and the Mediterranean region by three regional organizations (EMRO, SEARO and WPRO), Sub-Saharan Africa plus Algeria by one regional organization (AFRO) and Europe by one regional organization (EURO).

75. This pattern of regional organizations, which dates back to the early fifties, appears increasingly more like a permanent arrangement than a flexible geographical and organizational device for attaining the goals of WHO. In this regard, the Board's 1953 "Organizational Study of Regionalization" concluded that "the present six regions with their regional committees and offices are not necessarily permanent. The Health Assembly has full power to change, reduce or increase the number, with the sole restriction that the establishment of a regional organization within any geographical area defined by the Health Assembly is dependent on

the consent of a majority of the Members situated within each area....".

76. The Inspectors note that the original definition of regions and establishment of regional organizations were heavily influenced by historical antecedents, such as in the case of PAHO, which predates WHO by many years, or that of EMRO which grew out of the Egyptian Sanitary, Maritime and Quarantine Board and later the Pan-Arab Health Bureau. Political, linguistic, cultural and financial considerations have also tended to reinforce the permanent character of existing regional arrangements.

77. Notwithstanding these considerations, the Inspectors believe that substantial changes within the WHO setting since the early fifties argue for a careful review of the present delineation of some regions as well as territorial jurisdictions of some regional organizations in order to determine whether they have consistently remained effective tools of interaction between WHO and its Member States and constituency.

78. New developments in Eastern and Central Europe and Commonwealth of Independent States press for an appropriate organizational response. Close to 20 new Member States have been added to the membership of WHO's European Region. The main task at hand for WHO therefore is how to cope not only with this unprecedented expansion of membership but also, and more importantly, with the scale of health development needs in the new member States. In view of the fact that the WHO regular budget has been declining in real terms in the last decade, the mobilisation and channelling of external health resources into Eastern Europe and the new Republics must be high on the agenda of WHO. One option could be to create a distinct WHO "regional organization" for that purpose. Another option could be to manage the intercountry programmes for Western and Northern Europe directly from WHO headquarters so that the present WHO regional office for Europe can concentrate exclusively on the eastern part of the continent. Yet another option could be the establishment of appropriate WHO country or subregional presence in that part of Europe, taking advantage of integrated United Nations system offices recently established in some of the new Republics by the United Nations Secretary-General.

79. In the case of Africa, AFRO membership is not the same as that of the UN Economic Commission for Africa (ECA) or the organization of African Unity (OAU), which has instituted a Conference of OAU

Health Ministers. The size of the African region, the imminent admission of new Members to regional membership, intra-regional communication difficulties and the sheer magnitude of health problems in the region, also argue for a more innovative organizational approach to WHO's interaction with the regional membership and constituency. The establishment of three subregional offices in 1985-1986 corresponding to the OAU and ECA economic subregions appeared to offer a partial solution. It is not clear to the Inspectors why the experiment was discontinued even before it had become fully operational.

80. The AFRO Regional Committee should be requested, if deemed necessary, to propose options for strengthening WHO's operational interactions with the regional membership through an appropriate organizational set-up or redefinition of the AFRO geographical region without additional financial implications for WHO.

81. As regards the Pan-American Health Organization (PAHO), the Inspectors can only observe that Article 54 requiring its integration within WHO has remained a dead letter. As a consequence, PAHO enjoys the benefits of a dual personality: a strong regional organization benefiting from its international exposure through WHO. Since PAHO is not effectively integrated within WHO and is financed mainly by regional members, the recommendations of this report, if adopted, might not be legally binding on PAHO as it is not covered by the JIU Statute, unless its Members, who are also Members of WHO, decide that the recommendations be implemented.

82. The Inspectors further note that Article 35 of the Constitution which stipulates among other things the "internationally representative character of the Secretariat" is not being observed in all cases. This Constitutional provision should henceforth be applied in all regional offices and the necessary corrective measures should be introduced to ensure their world-wide international character, as recommended in Part I of the series on "Decentralization of Organizations within the United Nations System" (JIU/REP/92/6). If WHO's recruitment policy is indeed applied as it should be under the Constitution and staff regulations and rules, this recommendation should be easily applicable.

IV. MANAGEMENT ISSUES

A. Trends in resource allocations

83. The overall pattern of financial and staff resource allocations, including all sources of funds in the past decade, shows a general trend towards centralization in headquarters, as illustrated by figures 2 and 3 in the annex, which can be considered self-explanatory. The trend is more pronounced with respect to staff resources which decreased significantly at the country level as a proportion of total professional staff from 46 per cent in 1980 to 26 per cent in 1990. A projection of this trend suggests that by the year 2000 WHO would have very few professional staff at the country level and that close to two-thirds of the Organization's total staff resources would be concentrated in headquarters. This trend explains why headquarters premises have been expanding in the last couple of years.

84. These data may be subject to different interpretations by different WHO officials at the three geographical levels of the Organization. For the Inspectors, however, the data provide a graphic confirmation of the fact that the country level is losing out in the three-tier organizational "competition" for resources precisely when it should have been the focus of concentration of the organization's resources in support of the strategy implementation as prescribed in official documents. It is recognized that WHO is not essentially an operational organization in the same way as UNDP, UNICEF or WFP which are primarily concentrated at the country level, which WHO cannot do in each and every country. But the Inspectors could not ascertain whether resources allocated to the country level in general between 1980 and 1990 were concentrated in priority in the low income category of countries or on health system infrastructure and disease prevention and control, all of which would seem to qualify for WHO's affirmative action.

85. The Inspectors' discussions with WHO officials suggest that the Organization's current regular programme budgeting system and the Health Assembly resolution 29.48 of 1976 which mandated the distribution of regular budgetary resources between headquarters and the regions virtually make it impossible to shift resources among the different organizational entities, regions, countries and even programmes in order better to reflect new priorities. Probably for that reason the pattern of distribution of the Organization's

regular budgets in the past decade has remained practically the same, as though cast in concrete, even though the launching of the health for all strategy and its implementation requirements did imply a significant reshuffling of resource allocations. While two thirds or more of the regular budget was allocated to the regions between 1980 and 1990, the reverse was true for extrabudgetary resource outlays during the same period, as though to "compensate" for headquarters diminishing share of the regular budgets.

86. These trends, which confirm the "competition" for control of resources between the different levels of the Secretariat as pointed out in the DANIDA report, indicate that WHO's total resources tend to be concentrated at the headquarters and regional levels, both of which hold the levers of the organization's political and executive powers. This situation deserves the close attention of the Board which might wish to overhaul WHO's regular programme budgeting system and the pattern of extrabudgetary resource allocations to ensure that they fully promote priorities determined by the Health Assembly for the organization as a whole.

B. Technical programmes

87. The distribution of WHO's technical programmes and related resources are illustrated in figures 5 and 6. These programmes are those listed in the annex to the Eighth General Programme of Work of WHO, namely programmes and subprogrammes 3 to 13.18. Programmes implemented at all geographical levels number 48 and account for 50 per cent of total programme staff. This analysis, if confirmed, suggests considerable duplication of programme functions and resources at the three levels of the Organization. Should that be the case then the present three-layered technical programme structure of WHO is at variance with its allocation of functions and the programming criteria defined in official documents (see paragraphs 26-30, Chapter II). The impression of duplication is somewhat underscored by the similarity in staff profiles and grades particularly in the regional offices and headquarters, as pointed out in the Director-General's paper on the "Management of WHO's Resources". The overall picture gives the impression of seven different WHO organizations with similar programmes and staff profiles.

88. In addition, duplication does not seem to be limited only to the vertical axis of the Organization but exists as well on the horizontal axis, particularly at the country and headquarters levels where it appears exceedingly difficult to harmonize,

integrate or synchronize the thrusts of regular budgetary and extrabudgetary programmes in support of Member States. Headquarters-based programmes, for example, even when clinically arranged in a single division or department, operate independently of each other. One example is the Special Programme for Research and Training in Tropical Diseases (TDR), which is generally considered as being one of the most efficiently managed in the Organization, but which, however, duplicates much of the Division of Control of Tropical Diseases (CTD). While the former is funded mainly from extrabudgetary sources, the latter is sustained primarily by the regular budget.

89. TDR and other special, global or vertical programmes in headquarters are centralized, "stand-alone" entities, which could continue to function smoothly outside the WHO structure. They have distinct, donor-focused, supervisory management structures operating outside the authority and policy orbit of the Executive Board and Health Assembly. They also have their own duplicative administrative support services, information and communications systems, so much that in 1991, for example, the world-wide communications facilities of the Global Programme on AIDS (GPA) were reported to be more extensive and reliable than the "central" WHO network, itself fragmented into autonomous regional subsystems (e.g., AMPES, AFROPOC or WPRO/RIS).

90. Undeniably, these programmes have so far contributed immensely to strengthening the global technical leadership role and credibility of WHO in their areas of endeavours, such as AIDS, research in tropical diseases, appropriate technologies, essential drugs and vaccines, etc. Their present location in headquarters gives them the global visibility they need to galvanize international support for specific health problems. It also gives them a strategic focus on the scientific and donor communities with which they interact constantly. To remain effective, these programmes need to keep abreast of scientific and technological progress in the world and to compete at the global level for external resources which are contracting in a cash-strapped multilateral system.

91. In addition to the above reasons, others were mentioned as disincentives to further decentralization, such as the perceived "politicisation" of the regional structures which could complicate the discharge of accountability to donors for the proper use of their funds, or the absence in some regional offices of specialized skills or of appropriate staff profiles, and the generally weak

technical and managerial leadership of many WHO country representatives. The general impression is that the regional offices are more of an organizational constraint than a necessary operational facility for the delivery of field activities, and whatever token staff some of the programmes maintain in the regional offices seem to be dispensable. These observations would seem to corroborate the conclusions of chapter II about the shortcomings of WHO's decentralized system, which may have partly necessitated the global programmes.

92. From the field angle, on the other hand, the global or vertical programmes are generally perceived as tugging at WHO in the opposite direction of its constitutional structures and technical co-operation policies, which emphasize horizontal approaches and goals in support of national health systems (e.g. primary health care, community involvement and self-reliance, social equity, etc). The global programmes are thus considered to be a perpendicular obstacle to the pursuit of those goals. It is argued that the global programmes should concentrate on truly global issues such as research and development of new and appropriate concepts and technologies for tackling health problems, generation and dissemination of strategic information, fund-raising, etc, while leaving field implementation to the regional and country levels as required under the policies of the Executive Board and Health Assembly. In this regard, the retention and management by headquarters of support costs income accruing to the implementation of activities at the regional and country levels are a major bone of contention turning on the competition for resources among the various levels of the Organization.

93. The Inspectors conclude that the global programmes should for the time being remain centralized in headquarters for reasons noted in paragraph 91 above, but urge that if the recommendations of this report are implemented, particularly those in chapter III, all field-level implementation functions should be decentralized appropriately, together with support cost resources.

94. When the strong identity of individual global programmes and their distinct supervisory structures are considered in the light of the autonomous character of the six regional offices and their respective independent Regional Committees, and when to that is added the segmentation of WHO's information and communications networks and administrative support services, plus multiple funding tracks (regular budget and other funding sources), and limited staff exchanges/ rotation between programmes and entities, the

overall picture is one of organizational fragmentation verging on disintegration by mode of operation. The consequences include hobbled strategic direction of the Organization as a whole, high operational costs and functional inefficiencies due above all to the virtual impossibility to synchronize and coordinate cross-programme processes throughout the organization.

95. Yet, comprehensive, integrated programme thrusts, especially at the country level, are prescribed for WHO in the context of the health for all strategy by the Health Assembly, the Alma Ata Declaration on primary health care, and WHO's official documents. The Executive Board may wish to devise solutions for attenuating this major problem of duplication and lack of co-ordination among WHO's technical programmes, vertically and horizontally. A formalized, transparent and accountable system of functional complementarity needs to be instituted and enforced throughout WHO. If this is done, and the recommendations in chapter III implemented, financial and efficiency gains could be very significant, and the growing segmentation process would be reversed.

96. Analysis of programme resources by organizational entity (figure 6) shows widely varying levels of average resources and staff posts budgeted for each programme at headquarters and regional offices and among the latter. Headquarters-based programmes appear very well supplied relative to regional office programmes, probably because of their intensity and global nature. Besides that finding, the figure does suggest the absence of a system of priorities for programme areas of WHO involvement. The Organization's resources appear too thinly stretched over too many programmes, particularly in the regions. It must be wondered how effectively these programmes are being supported in addition to country-level programmatic demands.

97. If WHO is to shift gears towards intensified support for the health for all strategy implementation, it would be best advised to adopt a selective approach to technical co-operation with its Member States, such that enables it to concentrate its "critical mass" on the low income category of countries and on those programmes (e.g. health system infrastructure) likely to produce the most multiplier effects in other programmes areas. The rest of the programmes not eligible for priority attention could then be decentralized to the country-level. If WHO's co-ordinating, directing and normative role cannot be subcontracted under any circumstances, its technical co-operation functions could benefit

from more involvement by consultants, non-governmental organizations and other partners, within the framework of health policies established by WHO, and through the intermediation of WHO Country Representatives with duly enhanced management authority.

98. The Inspectors therefore recommend that WHO should develop a system of priorities enabling it to concentrate its resources on a narrower range of critical programmes and to decentralize as many programmes as appropriate to the country-level for support by other partners and WHO Representatives in agreement with the governments concerned. Additionally, Organization-wide standard criteria should be established for proportionally matching financial and staff resources to programmes in order to avoid the present inconsistent pattern of programme resource allocations in the different organizational entities, subject of course to specific programme needs and characteristics of each WHO region.

C. Health and Biomedical Information Programme (HBI)

99. Article 2 (q) and (r) of the Constitution would seem to indicate that the generation and dissemination of valid scientific and technical information by WHO should be pursued as a major Constitutional duty, and not as an appurtenant programme support function. Article VI of the Relationship Agreement between the United Nations and WHO further reinforces WHO's world-wide responsibility in this vital programme area. WHO publications, more than those of any other United Nations system organization, can save lives at relatively little cost, such as how-to-do manuals for the medical professions in the developing countries. WHO publications are also generally considered to be an authoritative, invaluable asset for teachers in health sciences and medical training institutions as well as for national health services. While WHO's official documents do stress the importance of generating and disseminating valid information as an integral part of technical co-operation with the countries, this is not clearly borne out by the way this function is now organized and by the attention and resources devoted to it, with wide variations between headquarters and the regions and among the latter.

100. While AMRO/PAHO and EURO, for example, seem to have established successful publications programmes, other regions are lagging behind. AFRO, for instance, has established an excellent health literature resource centre, but has not had a functioning publications programme for over a decade, which is astonishing considering the magnitude of health problems in this region which

need to be brought to the attention, through publications, of the international scientific and medical community. The Director-General is requested to take the necessary action to ensure that all regional offices have effective publications programmes forming an integral part of their technical programmes. It is also necessary to investigate how effectively WHO's publications are being disseminated and used in each region to support country activities, as emphasized by the Director-General in his 1987 paper on the "Management of WHO's Resources".

101. If WHO publications and documents are to serve effectively the purpose envisaged for them in official documents such as the General Programmes of Work, the "Managerial framework for Optional Use of Resources" or the "Regional Programme Budget Policy", serious consideration may have to be given to the possibility of transforming the Office of Publications into a full-fledged Division, as would be justified by relevant Constitutional provisions, with its budget contributed proportionately by all the technical programmes which must be required to originate publications materials. The same budgeting approach could be used in the regional offices. The proposed Division would then be given enhanced authority, under the guidance of the headquarters Publications Committee, to establish, co-ordinate and enforce publications policies and norms throughout the Organization, including global distribution and sales strategies.

102. The proposed Division would also be required to collaborate more intensely with the regional offices by way of publications staff training, study visits, exchanges and periodic rotation among the different organizational entities, all of which, most regrettably, does not happen at present, except for annual meetings with no real influence on the independence or neglect of some regional publications services. Another option worthy of further study could be centralized budgeting and management of headquarters and regional publications resources (except for PAHO) within the proposed new Division, in order to ensure that all the regional offices participate fully and evenly in generating and disseminating valid and appropriate scientific and technical information as an integrated component of their mainstream activities. WHO publications should also be more operationally and practically targeted to field-level health problems.

103. If publications policies, norms, priorities, budgeting, etc, are centralized, the other downstream functions in the publications chain (e.g., processing, printing, distribution, sales, monitoring,

evaluation and feed-back) could be decentralized and anchored firmly in the regional and country offices. By such dispensation, there would be one global WHO Publications Committee in headquarters having subcommittees in the regional offices, instead of several independent WHO publications committees, as at present. By the same token, there would be no more seven overlapping, unsynchronized WHO publications work programmes, but one annual or bi-annual work programme duly incorporating the priorities and inputs of regional publications subcommittees, and implemented through a rigorous functional division of labour between headquarters and the regional and country offices.

104. That way the Director-General and WHO as a whole can more effectively discharge accountability for the Organization's performance of its vital Constitutional functions relating to health information services. Likewise, the annual meetings of health and biomedical information officers would serve a truly useful substantive purpose, such as joint reviews of publications priorities, proposals and materials, production deadlines, planning distribution and sales strategies, allocation of tasks, exchange and rotation of staff, translation into local languages, evaluation of penetration and impact, stimulation and support of national health publishing policies and services, collaboration with other publishers within and outside the United Nations system, etc. A major question that deserves to be explored in depth is how to take optimal advantage of technological innovations to advance the objectives of WHO's health and biomedical information services. For example, the optical disc and CD-ROM technologies or the increased "publication" of video and audio tapes independently or in support of bibliographic publication, are but a few examples offering numerous advantages over conventional approaches.

D. Support services

105. **Decentralization pattern:** WHO's support services include personnel, budget and finance, general administration, and equipment and supplies to Member States. Figure 8 in the annex summarizes the degree and pattern of decentralization of three of these services in 1990. Headquarters officers responsible for these services have broad notions about the distribution of responsibilities and tasks between the regions and headquarters. Beyond that, however, there appears to be no formal, written framework of principles governing the allocation of responsibilities, functions and resources between the two levels. The pattern shown in figure 8 has remained virtually the same for

over a decade during which some regional programme operations have gained in intensity and scope.

106. While headquarters officials are satisfied that decentralization is in general working well in the support services, some regional offices complain about inadequate staff capacity. Figure 8 lends some credence to these complaints since headquarters alone accounts for close to 70 per cent of the resource allocations to the three services under review. When the duplicative support services of the special/vertical programmes are factored into this analysis, headquarters' share of the aggregate resources for support services rises to over 80 per cent, thus pointing up still another anomaly in the functioning of WHO's decentralized system. Indeed the operational programmes in the regions should, in principle, require more administrative backstopping than headquarters substantive programmes. Consideration should therefore be given to the possibility of unifying all headquarters-based programme support services irrespective of source of funding in order to release resources for strengthening regional/country support services.

107. **Staffing and grade trends:** Figure 4 in the annex summarizes the staff grade structure by geographical level for all professional staff in 1990. Table 1 below shows how total non-project professional staff and their grade structure have evolved from 1980 to 1991. On the basis of this table and information obtained from other sources the following observations can be made:

- (a) The non-project professional staff of WHO increased by 38 per cent between 1980 and 1991 even though its effective working budget declined by about 5 per cent in real terms during this period; the non-project professional staff of other comparable specialized UN agencies such as FAO, UNESCO or ILO declined between 1980 and 1991, mainly as a consequence of the zero-growth budget ceiling for all specialized agencies;
- (b) WHO professional staff are concentrated in the higher grades (P-4 to D-1/P-6) and the proportion of staff in these grades to total staff is steadily increasing, from 66 per cent in 1980 to 73 per cent in 1991;

- (c) the highest staff increase during the period under review was at the D-1 /P-6 level (66 per cent), followed by P-5 (52 per cent) and P-4 (50 per cent);
- (d) personnel costs (staff and consultants) as a proportion of WHO's total costs have increased from below 50 per cent in the early years of the organization to about 62 per cent at present.

TABLE 1: STAFF GRADE DISTRIBUTION: 1980 - 1991⁶
(Non project professional staff)

	1980	1991	% Increase/(decrease)
Total Prof. staff	806	1109	38%
UG	13	14	8%
D-2	31	39	26%
Subtotal (D-2 to UG)	44	53	21%
D-1/P-6	86	143	66%
P-5	280	426	52%
P-4	163	244	50%
Subtotal (P-4 to D-1/P-6)	529	813	54%
P-3	153	167	9%
P-2	71	66	(7%)
P-1	9	10	11%
Subtotal (P-1 to P-3)	233	243	4%

108. The above trends are quite indicative of serious management difficulties in WHO considering in particular that professional staff strength, grades and costs are increasing while the organization's overall performance seems to be declining as concluded in Chapter II.

⁶ ACC/1981/PER/14 (2 June 1981)
ACC/1992/PER/R.22 (7 October 1992)

109. The following personnel management weaknesses which were reported to the Inspectors in the course of this study may be responsible for the trends noted above:

- (a) Although the establishment and classification of professional posts and some recruitment functions are in principle centralized in headquarters, the regional offices usually sway headquarters personnel decisions, and especially their implementation in their respective regions. This is particularly so in recruitment matters whereby the regional offices routinely ignore shortlists established by headquarters. This partly explains why the professional staff composition of some regional offices has lost its world-wide international character over the years, in breach of article 35 of the WHO Constitution;
- (b) the mandatory retirement age is not uniformly observed, especially in the technical programmes where staff continue to serve several years beyond retirement age, or continue to serve as "consultants" after retirement;
- (c) the practice of personal promotions is no longer based strictly on exceptional merits;
- (d) there are apparently few systematic pre-recruitment checks to establish the accuracy of information supplied in job applications by selected candidates prior to their recruitment;
- (e) many recruitment actions are reported to be unduly influenced more by political calculations than by the requirements of excellence or real needs of the Organization;
- (f) Personnel management decisions, especially those concerning staff movements or transfers as well as promotions seem to be taken and implemented, particularly in the regions, without regard for their cost implications;
- (g) there is virtually no control over the use of consultants whose costs now represent about 5 per cent of the total costs of an Organization already staff-heavy;

- (h) although WHO is not quite precisely a "World Medical organization" and hardly performs medical duties, it tends to give pride of place and status to medical doctors, who are rarely recruited below P-5 level in the technical programmes. Other, no less important staff categories including especially the health sciences disciplines (eg. sanitary engineers, health economists and statisticians, public health administrators, etc.) and the whole range of intermediate technical staff likely to be recruited within the P-2/P-3 grade range, are relatively few and generally marginalized. The new staff profiles outlined for the Organization in the 1979 study on "WHO's structures in light of its functions" did not materialize with the result that WHO failed to shift from strategy conceptualisation and formulation to actual implementation.
- (i) Professional staff recruited in one region may be unacceptable in other regions, thus reinforcing the impression of uneven recruitment standards within WHO.

110. **Staff composition and rotation:** Tables 2 and 3 on page 43 underscore some of the problems noted above in personnel management. Table 2 which summarizes the composition of the different WHO organizational entities by origin of professional staff shows that only in South-East Asia (SEARO) and the Western Pacific (WPRO) especially have real efforts been made to achieve an internationally-diversified staffing pattern. Table 3 which traces professional staff movements among the different organizational entities between 1 January 1986 and 31 December 1990 confirms the insular character of these entities.

111. The Inspectors conclude that the personnel recruitment and management problems outlined above are sufficiently serious to justify a more elaborate investigation by the Executive Board, which may wish to enforce stricter implementation of the relevant staff regulations and rules concerning recruitment, grading and promotion practices, as well as the use of consultants and generalized exceptions to the mandatory retirement age, in view of their significant cost implications for the Member States. Pending such action as the Board may wish to take, the Director-General should provisionally restrict delegation of authority with respect to fixed-term professional appointments to enable him, under the guidance of the Board, to introduce and enforce corrective staff recruitment and management reforms throughout the Organization.

112. Firstly, personal promotions should be discontinued. Secondly, the staff composition of some regional offices should be corrected in accordance with article 35 of WHO's Constitution to ensure their world-wide international character. As a rule no more than 40 per cent of staff in the regional offices should originate from any one region. Thirdly, the mandatory retirement age should be systematically observed, with no exceptions. Fourthly, the use of external consultants should be subject to stringent formal guidelines to be developed by the Director-General and approved by the Board. Fifthly, an appropriate staff rotation policy involving the seven main duty stations should be introduced and backed by an intensive language training programme to satisfy the special linguistic requirements of some WHO regions (also see paragraphs 117 below). These measures should without doubt rid WHO of some of the handicaps and scale down the present high operational costs which inhibit the efficient functioning of its decentralized system.

113. Decentralization to the country level: None of the three support services under review is really decentralized to the country level, partly because WHO's decentralization policy hardly reaches out to the country level of the Secretariat. That policy requires Member States to be the real action arms of WHO within their respective territories. However, as pointed out in Chapter II and increasingly recognized by WHO itself under its "new strategy" of intensified support to countries in greatest need, WHO does need to adopt a more affirmative, pro-active approach to supporting countries unlikely by themselves to hold the health development line. If such an approach is adopted, especially for the low income countries, it would naturally become necessary to delegate increased authority and decentralize some support services functions to WHO offices in those countries eligible for affirmative actions, in view of the fact that for purely practical reasons some personnel, accounting and general administrative functions are usually better carried out at the country level.

Table 2: STAFF COMPOSITION OF THE WHO SECRETARIAT BY REGIONAL ORIGIN OF PROFESSIONAL STAFF AND ABOVE IN 1990

ORIGIN	TOTAL STAFF AT 31.12.90	HQ/ IARC		AFRO		AMRO		EMRO		EURO		SEARO		WPRO	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
AFRO	233	29	4.1	202	65.8	1	0.7	1	1.0	0	0.0	0	0.0	0	0.0
AMRO	375	157	22.0	25	8.1	134	87.6	13	12.9	5	7.0	18	17.8	23	23.5
EMRO	94	28	3.9	4	1.3	0	0.0	57	56.4	0	0.0	2	2.0	3	3.1
EURO	633	404	56.6	70	22.8	16	10.5	21	20.8	66	93.0	26	25.7	30	30.6
SEARO	96	29	4.1	2	0.7	1	0.7	7	6.9	0	0.0	49	48.5	8	8.2
WPRO	114	67	9.4	4	1.3	1	0.7	2	2.0	0	0.0	6	5.9	34	34.7

Table 3: MOVEMENT OF PROFESSIONAL STAFF FROM ONE ORGANIZATIONAL ENTITY TO ANOTHER: 1 JANUARY 1986 - 31 DECEMBER 1990

TO FROM	HQ/ IARC	AFRO	AMRO	EMRO	EURO	SEARO	WPRO
HQ/ IARC	X	26	2	6	5	8	7
AFRO	37	X	0	4	2	6	1
AMRO	8	1	X	0	0	0	0
EMRO	18	4	0	X	1	3	1
EURO	22	3	0	0	X	0	0
SEARO	16	2	2	11	0	X	3
WPRO	34	3	0	4	0	5	X

114. Decentralization of authority and functions to the country level obviously will centre around WHO Country Representatives. Many officials in WHO believe that a new generation of Country Representatives is required by the Organization for it to play an effective health leadership role at the country level. The Executive Board's 1978 "Organizational Study on WHO's Role at the Country Level, particularly the Role of the WHO Representative" did propose that the responsibility and authority of these officers be significantly enhanced. The responsibilities and functions enumerated in that study as well as in other WHO documents, such as the "Regional Programme Budget Policy" call for exceptional qualities in terms of vision and leadership aptitudes, technical qualifications, range and mix of international experience and managerial competence. As of now, it would appear that not all and probably very few WHO Representatives satisfy those requirements. It is reported for example that many Representatives are not capable of assisting Ministries of Health in the formulation of project proposals or documents needed to attract extrabudgetary funds. Again, the overall situation varies from one region to another.

115. In view of the above it may not be appropriate at this stage to decentralize some support services functions to the country level until a new generation of WHO Representatives is solidly in place, and local support staff have been trained and drilled in WHO financial and administrative procedures. However, WHO could and perhaps should take advantage of the fact that some support services now exclusively concentrated at the regional level can be performed in the countries where feasible through a UN system common services pool as may be developed increasingly in many countries for reasons of economy. In the same vein, WHO may wish to consider with UNICEF whether its Country Representatives with appropriate qualifications could not also serve as WHO Representatives in certain countries, and whether the practice of WHO Area Representatives, which it abandoned years ago, may not be worth re-introducing for economic reasons in certain cases, especially in Eastern and Central Europe and Commonwealth of Independent States.

116. **Special Services staff:** WHO's unique decentralized structure requires highly standardized methods and procedures throughout the Organization. This requires a highly competent, special services staff group constituting WHO's institutional memory and able to provide on-the-job guidance to subordinate staff. It would appear

that support services officers mentioned in paragraph 117 below do not all have such a profile and that they no longer rotate between headquarters and the regions and among these, following Health Assembly resolution 29.48 which seemingly limited the possibility to shift resources among the different organizational entities. Moreover, while WHO rightly allocates significant resources to the training of national health personnel, it seems to devote precious little to the training of its key staff.

117. The Inspectors recommend that, in order to promote uniformity of methods and procedures throughout WHO and further consolidate its unity of purpose and management, a number of key positions should be budgeted, filled and managed centrally, with the incumbents rotating every three or four years among the different regions and between the regional and headquarters levels. Such centralized management should not affect existing authority and reporting relationships between the officers concerned and the Regional Directors. The key positions identified by the Inspectors as absolutely eligible for such central management and for continuing in-service training within and outside of WHO, are:

- (a) WHO Country Representatives (WR)
- (b) Technical Programme Managers (PM)
- (c) Directors of Support Programmes (DSP)
- (d) Administrative Management Officers (MGT)
- (e) Publications/Reports officers (PUB)
- (f) Editors and translators
- (g) Personnel officers (PER)
- (h) Budget and Finance officers (BFO)
- (i) Supply officers (SUP)
- (j) Administrative Services officers (ASO)

118. Country Representatives and Technical Programme Managers should be alternating in addition to their geographical rotation. Also the possibility should be studied of considerably strengthening Administrative Management positions or units in each

regional office. Because WHO's decentralized system is likely to rise or fall on the shoulders of the officers listed above, the Inspectors strongly urge that their recruitment and administration not only be centralized entirely but should also be based on new and enhanced standards. All necessary staff changes should be introduced to comply with the new profiles within a three-year time frame for example.

119. Supply of equipment to Member States: Two problems are worthy of note under this heading. The first is that headquarters supply officers very seldom visit the developing countries to acquaint themselves with local supply conditions and opportunities. Regional supply officers are presumably expected to be conversant with such conditions and opportunities, but they, too, hardly travel for information gathering purposes within their respective regions. The second problem concerns the absence of feedback information on the relevance, performance and general state of equipment purchased and supplied by WHO to Member States and costing over US\$ 50 million per annum. Under WHO's policy of decentralization the Organization's technical co-operation resources, including equipment and supplies, "belong" to member States which, however, are expected to account for the proper use of those resources in accordance with WHO's policies and guidelines. But neither the first nor the second strategy evaluation (see Chapter II) included a special heading under which governments or WHO itself could account to the governing bodies for the use, maintenance or disposal of the equipment and supplies provided by the Organization since 1979, at an estimated cumulative cost of over US\$ 600 million. The Executive Board could direct the secretariat to evaluate this programme every two years.

120. As this report was being finalized, more data were supplied by WHO on the pattern of allocation of its regular budget and extrabudgetary resources in 1992. The data are reproduced below for all intents and purposes.

ALLOCATION OF TOTAL REGULAR PROGRAMME RESOURCES IN 1992

(a) By organizational level

	US\$ million	%	Prof. staff and above	%
HQ/Interregional	128.8	35	375	39
Regional/Intercountry	104.8	29	302	31
Country	133.8	36	294	30
TOTAL	367.4	100	971	100

(b) By region

	US\$ million	%	Prof. staff and above	%
AFRO				
Regional	30.3	12	59	10
Country	37.9	16	104	17
AMRO				
Regional	18.7	8	53	9
Country	17.1	7	85	14
EMRO				
Regional	11.6	5	54	9
Country	25.2	10	30	5
EURO				
Regional	21.6	9	63	11
Country	1.3	1	-	-
SEARO				
Regional	9.7	4	36	6
Country	33.8	14	35	6
WPRO				
Regional	12.9	5	37	6
Country	18.5	8	40	7
TOTAL	238.6	100	596	100

ALLOCATION OF TOTAL EXTRABUDGETARY RESOURCES IN 1992

(a) By organizational level

	US\$ million	%	Prof. staff and above	%
HQ/Interregional	248.3	50	272	52
Regional/Intercountry	152.2	30	47	9
Country	99.1	20	206	39
TOTAL	367.4	100	525	100
(b) By region				
	US\$ million	%	Prof. staff and above	%
AFRO				
Regional	36.2	15	11	4
Country	19.9	8	112	44
AMRO				
Regional	91.1	36	11	4
Country	49.9	20	22	9
EMRO				
Regional	3.4	1	8	3
Country	6.1	2	7	3
EURO				
Regional	7.6	3	4	2
Country	0.6	-	14	6
SEARO				
Regional	5.1	2	7	3
Country	15.4	6	26	10
WPRO				
Regional	8.8	4	6	2
Country	7.2	3	25	10
TOTAL	251.3	100	253	100

IV. CONCLUSION AND RECOMMENDATIONS

A. Conclusion

121. In several respects WHO represents a unique global resource for the international community, but its vast potential is yet to be realized to its optimal pitch. It has an excellent constitutionally decentralized structure whose efficient functioning is, however, inhibited by several factors of a political, managerial and programmatic character. It has very effectively performed its global co-ordinating, directing and normative functions, particularly by launching and promoting the strategy for health for all by the year 2000. But its technical co-operation role has not been uniformly effective in supporting Member States in the implementation of that strategy. The reasons for this are complex and are to be found at the country, regional and headquarters levels which share responsibility for the strategy implementation and optimal use of WHO's resources and represent the main levers of decentralization in the Organization.

122. The Inspectors conclude that because WHO's decentralized structure is currently handicapped by many problems identified in this report, it is not functioning as efficiently and effectively in the nineties as it did in the early decades of its existence. Throughout its history WHO has demonstrated a remarkable capacity for self-evaluation as exemplified by the many organizational studies of the Executive Board. It is the Inspectors' conviction that WHO can become, once again, the premier organization that it was in the past within the United Nations system and community of nations, provided that the Executive Board revitalizes its management oversight authority in conformity with the Constitution and introduces the courageous reforms necessary to that end. Accordingly the Inspectors offer the following summary of their main recommendations while drawing attention to other recommendations contained in the body of the present report.

B. Recommendations

RECOMMENDATION 1: EXECUTIVE BOARD

The Executive Board may wish to consider revitalizing its management oversight authority as provided in the Constitution by; inter-alia:

- (a) Ensuring that an appropriate proportion (e.g. 20 per cent) of Board Members, Alternates and Members' Advisers are experts in management, administrative and budgetary matters.
- (b) Establishing a watchdog subcommittee on administrative and budgetary questions, with a small standing secretariat, whose functions would be similar to the United Nations Advisory Committee on Administrative and Budgetary Questions (ACABQ).
- (c) Initiating a comprehensive review of the functioning and structuring of WHO's technical programmes with a view to correcting staff profiles, weeding out duplication and instituting functional complementarities as well as co-ordinated approaches on the horizontal and vertical axes of the organization.
- (d) Initiating a comprehensive review, with the assistance, if necessary, of external management consultants, of WHO's staff recruitment, grading and

promotion policies and practices with the objective of reversing rising staff costs and grade escalation throughout the Organization.

RECOMMENDATION 2: REGIONAL COMMITTEES

The Executive Board may wish to consider revitalizing its management oversight authority as provided in the Constitution by; inter-alia:

- (a) The Regional Committees should further shift the emphasis of their work to technical and operational issues relating to the implementation and evaluation of regional strategies for health for all.
- (b) The level and qualifications of representatives to the Regional Committees should be reviewed and very clearly defined below Ministerial level to reflect the proposed change of emphasis and the need for continuity of policy implementation in the Member States of each region. The Regional Committees could continue to meet at Ministerial level during sessions of the Health Assembly.

- (c) A more structured authority and reporting relationship should be instituted between the Regional Committees and the Board.
- (d) The Regional Committees should meet every two years, preferably during programme budget years, to ensure optimal use of resources.

RECOMMENDATION 3: THE REGIONAL DIRECTORS (RD)

- (a) The Director-General should be empowered to select and nominate RDs for confirmation by the Executive Board, following consultations and in agreement with the Regional Committees concerned or their Bureaux, as appropriate.
- (b) The selection and consultation processes should be handled confidentially by the DG to preclude any open competition for the RD position.
- (c) The term of office for all RDs, including the RD for AMRO/PAHO, should be five years, renewable once. This recommendation could also apply to the DG.
- (d) The RD post description should be modified to allow for substantial decentralization of some of their authority and functions to WHO Country Representatives in country programme management, administration and resource mobilization, in conformity with financial regulations and rules and resolutions of the governing bodies.

RECOMMENDATION 4: TECHNICAL PROGRAMMES

- (a) WHO should develop a new framework of technical co-operation programme priorities enabling it to concentrate its "critical mass" on the low income countries and on a narrower range of regular programmes, and to decentralize as many programmes as may be found appropriate to the country level for support by governments themselves, WHO Representatives and other partners.
- (b) Subject to the acceptance and implementation of recommendation 3, the field-level implementation functions now carried out by some global programmes in headquarters should, thereafter, be decentralized as far as feasible together with related support costs resources.

RECOMMENDATION 5: HEALTH AND BIOMEDICAL INFORMATION SUPPORT

Consideration should be given to enhancing the authority and status of the office of publications to the level of a full-fledged Division for reasons and purposes described in paragraphs 99-104 of the present report and all regional offices should be enabled to participate fully in generating and disseminating health information.

RECOMMENDATION 6: SUPPORT SERVICES

A unified management information system and communication system should be established to integrate all organizational entities, programmes and country offices. Similarly, the different headquarters' support services should be integrated within the support programme irrespective of funding sources and principles should be devised to govern the apportionment of support services resources between headquarters and the regions.

RECOMMENDATION 7: BUDGET AND FINANCE

- (a) The present regular programme budgeting system may need to be reviewed and, if necessary, altered to ensure that it can be used more effectively to address the evolving global priorities of the Organization.
- (b) Financial regulations and rules should be clarified and, where appropriate, updated in the light of Health Assembly resolution 34.37 so that Regional Directors and Country Representatives can participate more effectively in mobilizing and accounting for extrabudgetary resources in the same way as headquarters-based programmes.

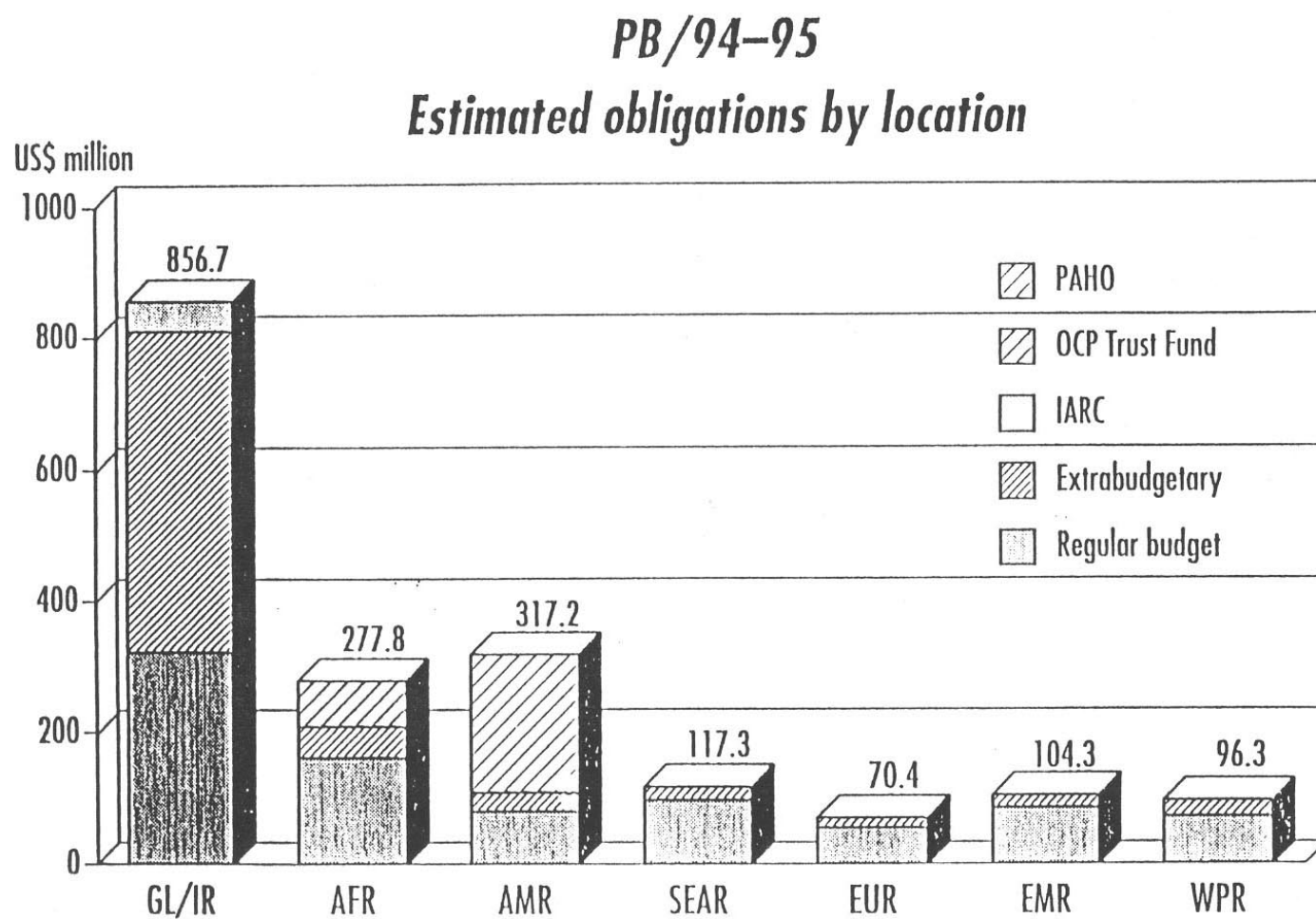
RECOMMENDATION 8: PERSONNEL ISSUES

- (a) Pending action on recommendation 1 (d) and taking into account to the extent possible the views of all those concerned, all recruitment actions in respect of fixed-term professional posts should be centralized on a provisional basis to enable the Director-General to accomplish the following within a three-year time frame.
- (i) Correct where necessary the professional staff composition of the regional offices in line with Article 35 of the

Constitution so that no regional office should have more than 40 per cent of its professional staff from a single region of WHO.

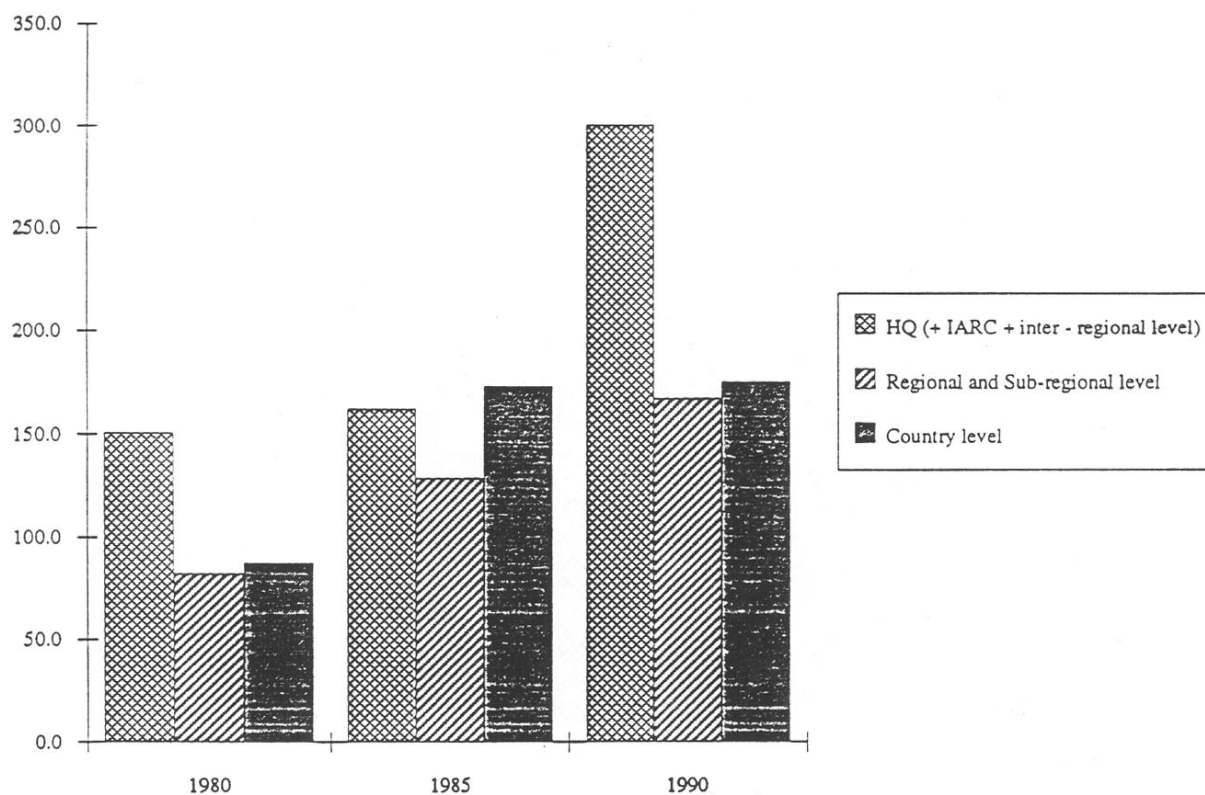
- (ii) Establish a new generation of WHO Country Representatives possessing the high qualities of leadership, technical aptitudes and managerial experience and competence required of them in WHO official documents; they should have new job descriptions reflecting significantly enhanced delegation of responsibility and authority in country programme management, administration and resource mobilization.
- (iii) Establish a special services staff category comprising, in addition to Country Representatives, Technical Programme Managers, Directors of Support Programme, Administrative Management specialists, Publications officers, Editors and Translators, Personnel officers, Budget and Finance officers, Supply officers and Administrative Services officers; these positions should be budgeted, filled and administered centrally in headquarters without affecting their lines of authority to the RDs; the officers should receive in priority periodic in-service training and retraining within and outside of WHO; they should have new job descriptions in line with the exceptional level of qualifications, experience and competence required for their positions; and they should be rotated every three or four years among the regions and between the regions and headquarters.
- (b) Personal promotions should be discontinued at present in the near future.
- (c) The use of external consultants should be subject to new stringent guidelines to be developed by the DG and approved by the Board.
- (d) The mandatory retirement age should be more systematically observed.

Figure 1



Decentralization of Total Financial Resources in Million US\$ (1980 - 1990)

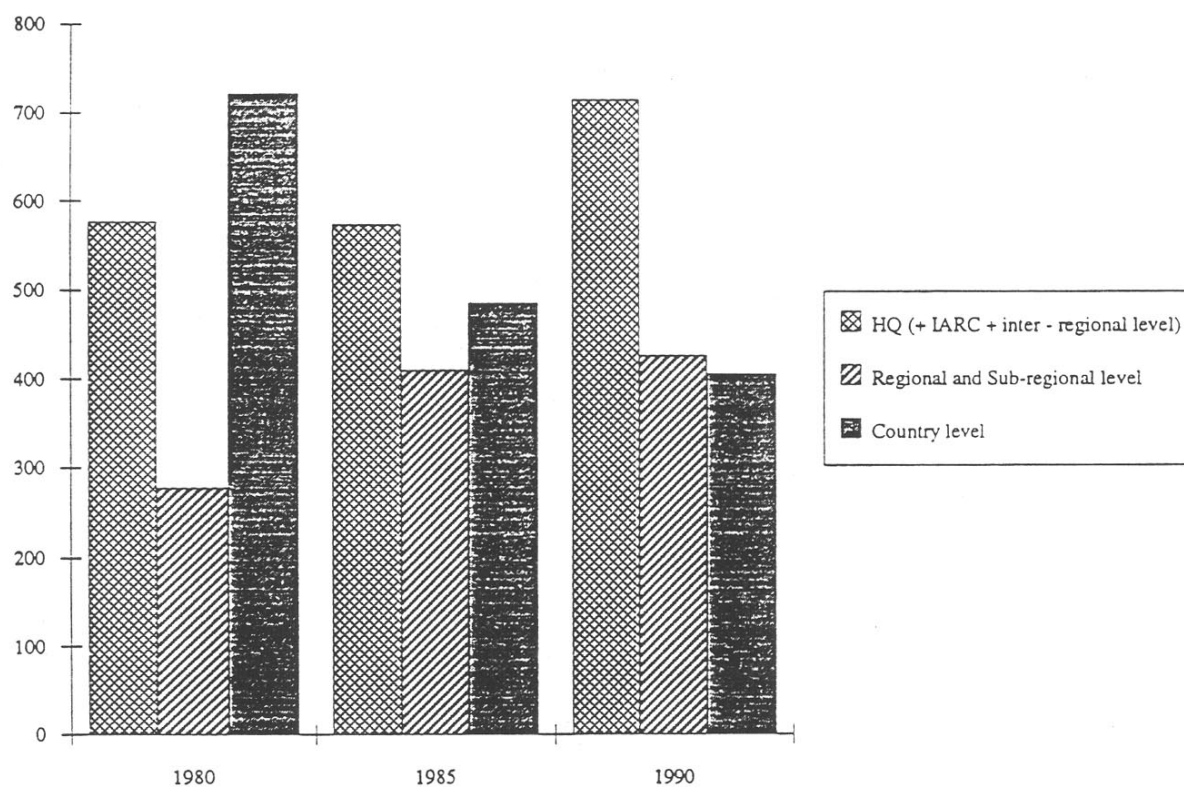
Figure 2



	1980	1980%	1985	1985%	1990	1990%	Increase % 1980/1990
HQ (+ IARC + inter - regional level)	150.7	47.0 %	162	34.9 %	300.3	46.7 %	99.3 %
Regional and Sub-regional level	82.4	25.7 %	128.5	27.7 %	167.2	26.0 %	102.9 %
Country level	87.5	27.3 %	173.2	37.4 %	175	27.2 %	100.0 %
Total	320.6	100.0 %	463.7	100.0 %	642.5	100.0 %	100.4 %

Decentralization of Total Professional Staff & Above (1980 - 1990)

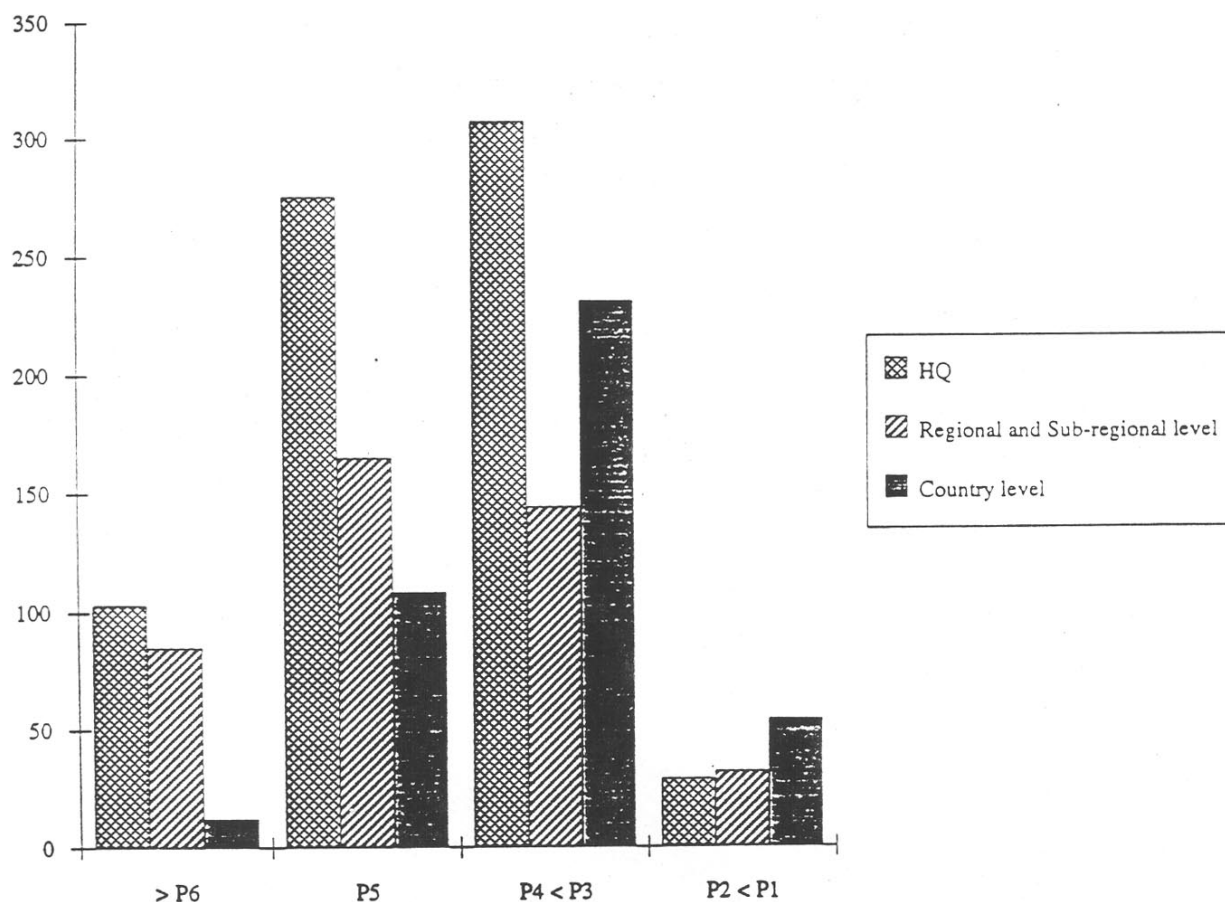
Figure 3



	1980	1980%	1985	1985%	1990	1990%	Increase % 1980/1990
HQ (+ IARC + inter - regional level)	577	36.6 %	574	39.1 %	714	46.2 %	23.7 %
Regional and Sub-regional level	278	17.6 %	410	27.9 %	426	27.6 %	53.2 %
Country level	722	45.8 %	485	33.0 %	405	26.2 %	-43.9 %
Total	1577	100.0 %	1469	100.0 %	1545	100.0 %	-2.0 %

Decentralization of Professional Staff and Above by Grade

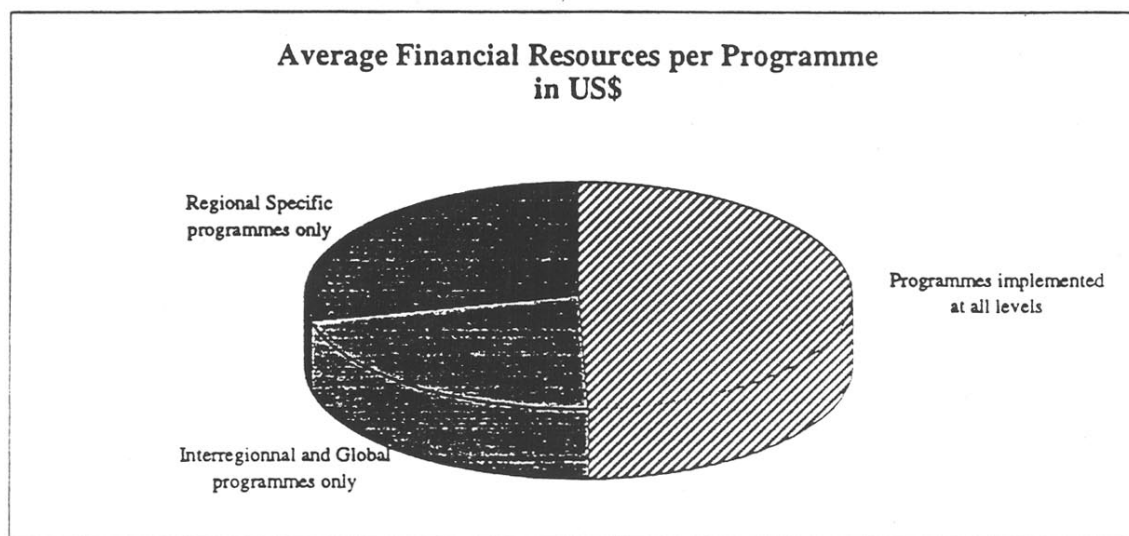
Figure 4



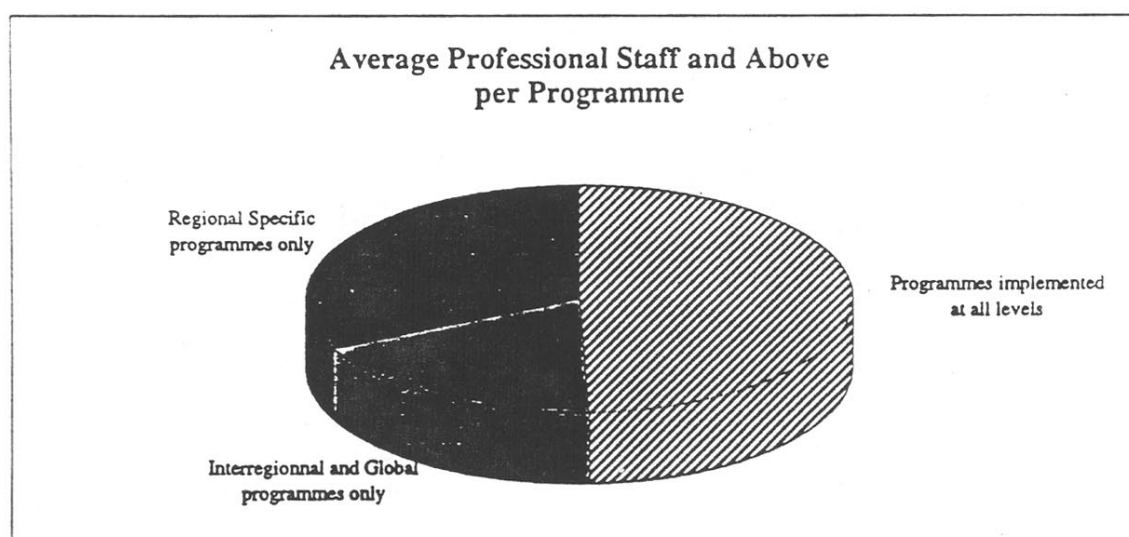
	> P6	P5	P4 < P3	P2 < P1
HQ	103	275	307	29
Regional and Sub-regional level	85	165	144	32
Country level	12	108	231	54
Total	200	548	682	115

Pattern of Distribution of Programmes in 1990 by Organizational Level

Figure 5



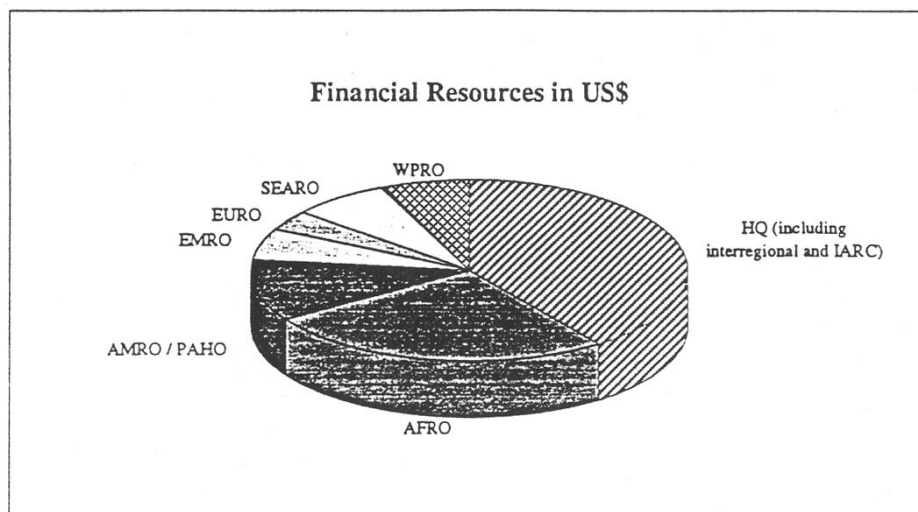
	Number	US\$	US\$ per Programme
Programmes implemented at all levels	48	488 192 015	10 170 667
Interregionnal and Global programmes only	48	213 736 652	4 452 847
Regional Specific programmes only	47	274 455 363	5 839 476



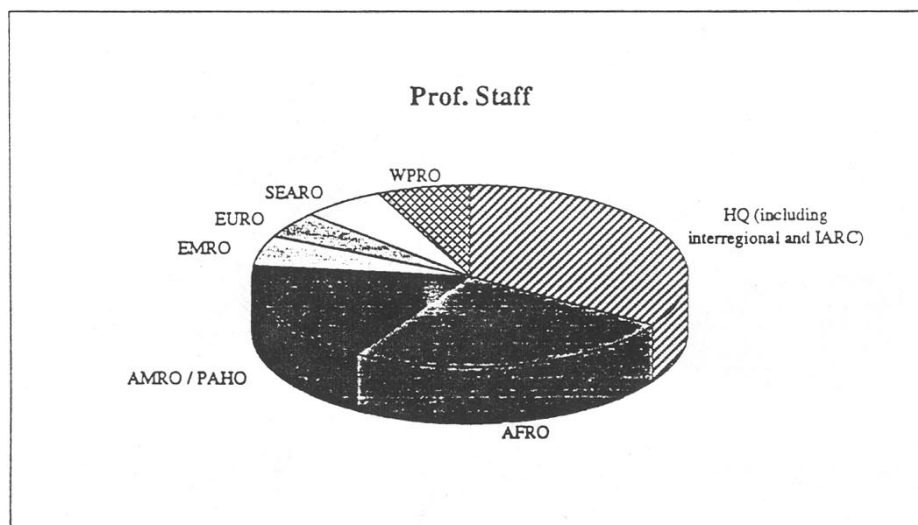
	Number	Total Prof. Staff	Total Prof. Staff per Programme
Programmes implemented at all levels	48	1 115	23
Interregionnal and Global programmes only	48	407	8
Regional Specific programmes only	47	708	15

Pattern of Distribution of Programme Resources in 1990 by Organizational Entity

Figure 6



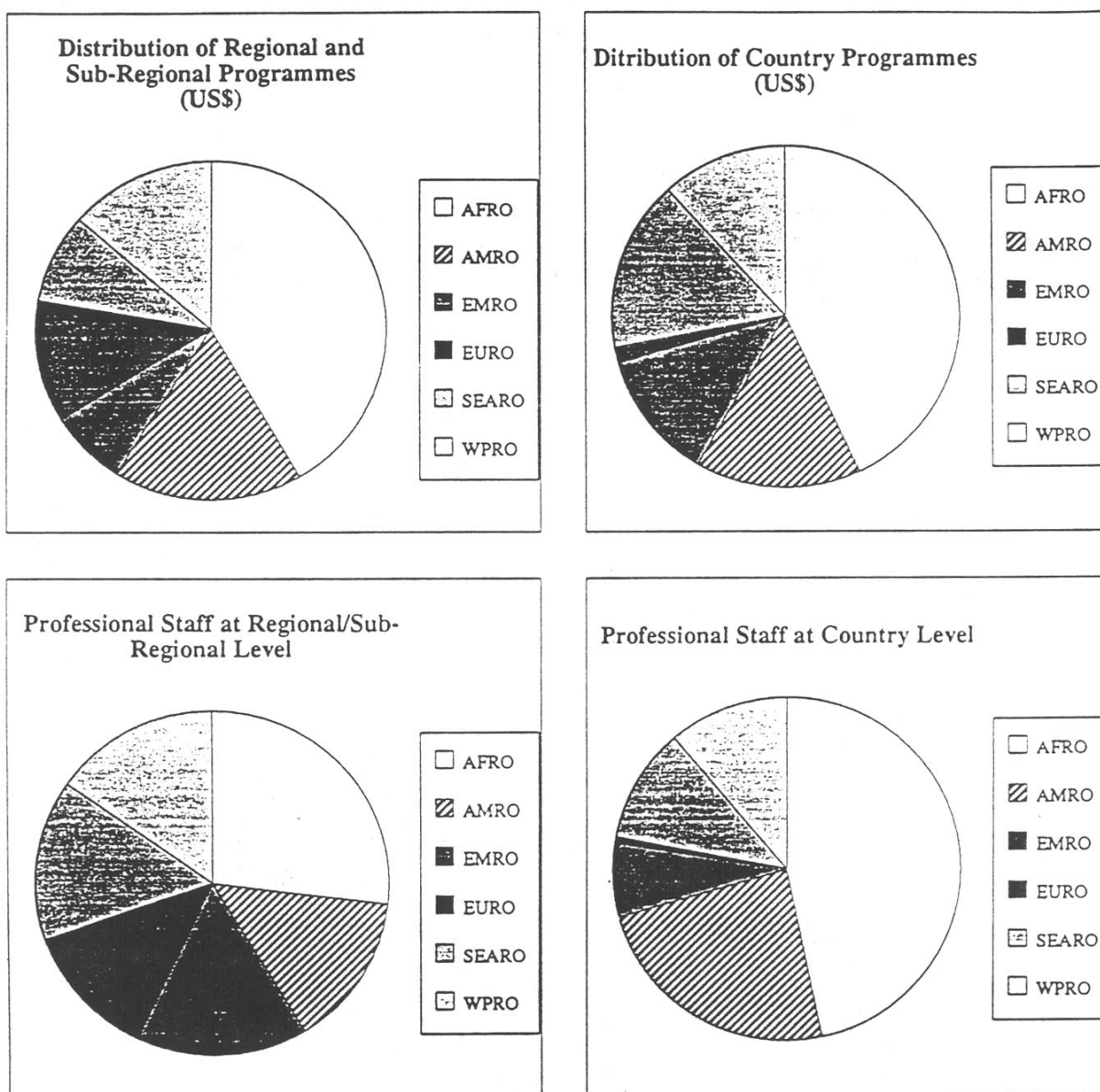
	Number	US\$	US\$/Prog
HQ (including interregional and IARC)	48	213 736 652	4 452 847
AFRO	42	119 279 659	2 839 992
AMRO / PAHO	35	43 432 599	1 240 931
EMRO	46	27 972 045	608 088
EURO	35	14 297 331	408 495
SEARO	47	36 370 152	773 833
WPRO	45	33 103 577	735 635



	Number	Prof.	Prof./Prog
HQ (including interregional and IARC)	48	467	10
AFRO	42	255	6
AMRO / PAHO	35	132	4
EMRO	46	66	1
EURO	35	34	1
SEARO	47	80	2
WPRO	45	81	2

Resource Allocations to Regional and Country Programmes in 1990

Figure 7



Distribution of Financial and Human Resources by Region in 1990

	Regional (US\$)	Sub-Regional (US\$)	Country Level (US\$)	Prof. Staff at Country Level	Prof. Staff at Regional Level
AFRO	42 568 893	3 917 041	72 793 725	189	66
AMRO	17 789 190	...	25 643 409	97	35
EMRO	7 310 920	...	20 661 125	28	38
EURO	11 967 938	...	2 329 393	3	31
SEARO	8 876 750	...	27 493 402	44	36
WPRO	13 631 582	...	19 471 995	44	37

Staffing and Cost of Three Selected Support Services in 1990

Personnel Services in 1990

	Prof. Staff	1) Total Cost US\$	Prof. Staff %	Total Cost %
HQ	15	4 139 382	52%	63%
AFRO	5	782 417	17%	12%
AMRO / PAHO	3	417 069	10%	6%
EMRO	2	199 943	7%	3%
EURO	1	500 531	3%	8%
SEARO	2	277 197	7%	4%
WPRO	1	208 616	3%	3%

Budget & Finance Services in 1990

	Prof. Staff	1) Total Cost US\$	Prof. Staff %	Total Cost %
HQ	37	10 047 034	67%	71%
AFRO	6	1 718 242	11%	12%
AMRO / PAHO	4	711 289	7%	5%
EMRO	2	265 113	4%	2%
EURO	3	776 502	5%	5%
SEARO	2	360 153	4%	3%
WPRO	1	360 189	2%	3%

Supply Services in 1990

	Prof. Staff	1) Total Cost US\$	Prof. Staff %	Total Cost %
HQ	7	3 326 046	54%	74%
AFRO	1	427 494	8%	9%
AMRO / PAHO	2	142 166	15%	3%
EMRO	1	156 576	8%	3%
EURO	...	65 939	...	1%
SEARO	1	163 473	8%	4%
WPRO	1	236 820	8%	5%

1) including Professional and General Service Staff Costs

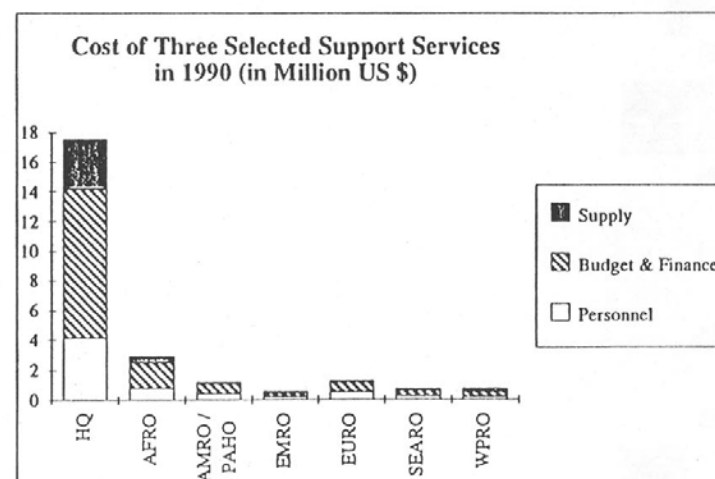
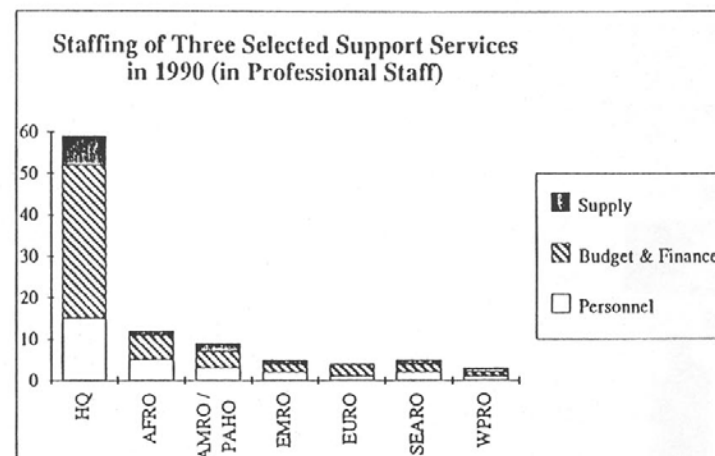


Figure 8