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REVIEW OF MANAGEMENT, ADMINISTRATION AND DECENTRALIZATION IN THE WORLD HEALTH ORGANIZATION (WHO)

Part II

Review of Decentralization in WHO

Prepared by

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Joint Inspection Unit

Geneva 2012

United Nations

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EXECUTIVE SUMMARY

Part II: Review of Decentralization in the World Health Organization

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The concept of decentralization at the World Health Organization (WHO) is enshrined in the Organization's Constitution, which led to the creation of six regional organizations composed of a regional office and a Regional Committee each.

More than six decades after its creation, the decentralization at WHO still faces the challenge of proper resource allocation based on transparent and clear criteria, which is not unusual to any decentralization process. The agreed ratio of a 30:70 allocation of resources between headquarters and regions has not been attained, and the gap between resources planned and actually allocated is noticeable to the benefit of headquarters, although it has improved in recent years. Measures are needed to ensure a more transparent allocation of resources not only from headquarters to regions but also from regions to countries. Criteria for a minimum country presence should be defined and maintained only when there is a critical volume of programmes as well as capacity in number and qualifications of staff to be effective. Otherwise, it would be more cost-effective to cover such countries from a neighbouring, well-established country office or directly from the regional office.

The second main challenge to decentralization at WHO is the consistent implementation of policies, routine administrative services and related controls across the Organization. This is often a source of duplication, loss in economies of scale and inefficiency.

There is a third challenge relating to the ambiguity of the chain of command and accountability in practice. The powers vested by the Constitution in the Regional Directors as elected officials weaken the authority of the Director-General as chief technical and administrative head of the Organization, compared to other United Nations system organizations, and have been a source of tension in their relationship in the past, although this has improved in recent years with the creation and enhanced functioning of the Global Policy Group (GPG). The functioning of the GPG, together with the numerous coordination mechanisms set up at all levels of the Organization in technical and administrative areas, as well as the introduction of the WHO General Management System (GSM) and the Global Service Centre, have brought greater coherence to the work of the Organization. As a result, a new corporate management culture is emerging. However, a lot remains to be done to harmonize policies and procedures across the Organization and enhance the effectiveness of these coordination mechanisms which do not always function regularly in all areas between headquarters and the regions, or are not always effectively reproduced between regions and countries, and are affected by resource constraints. A better harmonization of regional and headquarters organizational structures would also serve the purpose of working together as "One".

The delegation of authority, which is the backbone of any decentralization process, appears overall to be satisfactory across the Organization, although it can be enhanced in certain areas, such as mobilization of resources, recruitment, procurement and travel. At country level, the delegation of authority to heads of country offices varies across the regions and should be better tailored to the size, capacity and operational needs of the country offices. The perception of staff about how clear and well documented the delegation of authority is shows diverse views Organization-wide.

Better defined monitoring and accountability mechanisms for Regional Directors are needed to monitor the implementation of the authority delegated to them and to assess their performance. The Joint Inspection Unit survey disclosed that the accountability of managers is a critical issue in the perception of staff, which also differs widely across the Organization.

Other issues noted by the Inspectors were:

- The existing delineation of the African and Eastern Mediterranean regions and size of regions and existence of two Asian regions are sources of operational constraints when it comes to dealing with common health issues, and are not fully justifiable on the basis of organizational, public health, or economic considerations. The lack of alignment of WHO regions with existing regions at other United Nations system organizations has an impact on how they work together. Recognizing that this is a highly political issue, the Director-General is invited to undertake consultations with the countries and regions concerned on the redefinition of the current regional design and to seize any opportunity to bring the issue to the World Health Assembly;

- The integration of the Pan American Health Organization (PAHO) into WHO is a slow but sustained process in the strategic and programmatic area, which has not been fully operationalized in the administrative area and should be further advanced. An interface should be created between the enterprise resource planning system under development at the WHO Regional Office for the Americas/PAHO and the existing GSM at WHO to enhance integration;

- The multiplicity of committees and subcommittees at regional level make the governance machinery of the Organization more complex, while not necessarily more effective. Overall, the inter-sessional work of the regional governing bodies needs to be strengthened, their oversight of the work of regional offices in general is weak and the linkages among them and with the global governing bodies need substantive improvement. A comprehensive review of the governance process at regional level should be undertaken, and the harmonization of the rules of procedures, including the nomination process of the Regional Directors should be completed;

- The country support units at headquarters and in most regions have played an important role and should continue to do so. The Department of Country Focus at headquarters should focus on normative and monitoring work, aiming at harmonizing practices and creating synergies among regions and the work of the different country support units/functions. A common set of objectives and indicators specific to the work of these offices should be set up and their achievement monitored. It is proposed that an evaluation of the work of the country support function at headquarters and regional levels should be conducted. The Country Support Unit network should take a step forward to leverage its role in harmonization and decision-making, bringing concrete proposals for inclusion in the agendas of the GPG and Directors of Programme Management meetings;

- The use of the Country Cooperation Strategy (CCS) in the WHO planning process should be further enhanced to better reflect country priorities and needs. The implementation of the CCS should be monitored and reported on properly. The revised CCS Guide developed in 2010 includes for the first time guidance to review the WHO performance in countries. It is recommended that the Department of Country Focus at headquarters and the respective country support units/functions at regional level guide this review process to ensure coherence across the Organization;

- There are too many types of Heads of WHO Country Offices (HWCOs) and these should be streamlined. The appointment of National Professional Officers to head operations of country offices should be gradually discontinued. The grades of HWCOs are not always in line with the complexity of the country offices and should be reclassified accordingly**.** The process of selecting and training heads of country offices has been significantly improved and should be further enhanced to ensure greater diversity, among other things, in gender. Training should be made mandatory for all serving HWCOs. The mobility of HWCOs differs among regions; it is mostly exercised within regions and with different time limits. A mobility policy for HWCOs should be designed and implemented Organization-wide, whereby in the interests of cross-fertilization, a maximum number of years for rotation is set by category of duty stations and among regions and headquarters. Such a policy should be approved by the GPG and the regions should abide by it; implementation and exceptions should be monitored and reported to the GPG and the governing bodies;

- Interregional cooperation activities are not planned, financed and pursued in programme budgets and work plans. The inflexible budgetary planning and reporting system rather impedes the financing and implementation of any such initiatives even though they are not necessarily expensive. At corporate level, there is a need to design a strategy, allocate resources and define roles and responsibilities in support of such cooperation. Country offices should be tasked with identifying potential areas of cooperation within the specific country needs. Regional offices should set up mechanisms to disseminate knowledge within the region, and play a role in matching needs with capacity in other countries outside or within the region, and in bridging provider and recipient countries in mutually beneficial arrangements; and

- WHO participation in multi-sectoral health programmes and activities at country level should be rendered more effective. To this end, WHO country offices should be provided with improved guidance, tools and possibilities and HWCOs empowered to be operative and capable partners. An Organization-wide strategic approach is needed to remodel the present system of managing United Nations cooperation issues and reposition WHO as an important partner in development. The annual report to the World Health Assembly "Collaboration within the United Nations system and with other intergovernmental organizations" should be discontinued and replaced by more substantive strategic reports every two years.

The Inspectors have refrained from making recommendations on a number of issues which are being addressed in the ongoing reform process and proposals. They have formulated six recommendations, of which five are addressed to the Director-General for implementation, and the recommendation below, which requires action by the Executive Board.

Recommendation 1

The Executive Board should complete, in the context of the current WHO reform process, a comprehensive review of the governance process at regional level and put forward concrete proposals to improve the functioning of Regional Committees and subcommittees and finalize the harmonization of their rules of procedure for the consideration of Regional Committees.

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ABBREVIATIONS

AFRO	WHO Regional Office for Africa
AMRO	WHO Regional Office for the Americas
CCS	Country Cooperation Strategy
CCO	Department of Country Focus
CSU	Country Support Unit
EB	Executive Board
EMRO	WHO Regional Office for the Eastern Mediterranean
ERP	enterprise resource planning
EURO	WHO Regional Office for Europe
GPG	Global Policy Group
GPW	General Programme of Work
GSM	WHO Global Management System
HOC	Head of Country Office
HWCO	Head of WHO Country Office
IST	intercountry support teams (Africa Region)
JIU	Joint Inspection Unit
LO	Liaison Officer
MTSP	Medium-term Strategic Plan
NPO	National Professional Officer
PAHO	Pan American Health Organization
PMDS	performance management and development system
SEARO	WHO Regional Office for South-East Asia
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
WHA	World Health Assembly
WHO	World Health Organization
WPRO	WHO Regional Office for the Western Pacific
WR	WHO Representative

INTRODUCTION

1. Decentralization is commonly defined as the distribution of financial resources and the transfer or delegation of authority and decision-making power and the assignment of responsibility and accountability for results among different levels of a government or organization. Decentralization helps alleviate bottlenecks in decision-making and can increase sensitivity to local conditions and needs. But decentralization does have disadvantages; it is not efficient for standardized, routine services and can make the equitable distribution of resources more difficult when they are scarce and may result in loss of economies of scale and control over scarce resources. When there is weak capacity at local level, decentralization may result in less effective delivery of services. It also makes coordination of policies more challenging. Delegation of authority is defined as the devolution of the right and power to act in a particular job or function to enable the holder to fulfill his/her responsibilities. It includes the right to command and the right to commit resources. To be effective, the authority delegated should be consistently and clearly defined in general administrative instruments or individual delegation orders, determining who is responsible for doing what and what the limits are and thresholds applied to exercise such authority, in a clear and unambiguous vertical chain of command.[1]

2. At the World Health Organization (WHO) the concept of decentralization has been enshrined from its creation in the Organization's Constitution, which provides for the set-up of regional organizations to meet specific regional needs. Each regional organization consists of a Regional Committee which is composed of Member States and the associate Member States in the region and adopts its own rules of procedure, and a regional office which is the administrative organ, headed by a Regional Director.[2] They are an integral part of the Organization, but actually function with a high degree of autonomy, as in a federative state.

3. Although the initial concept of regional decentralization at WHO, which has historical roots in previous regional health and sanitary organizations, has never been questioned, its efficiency and effectiveness have been the subject of periodic examination by Member States and the management of the Organization. The JIU reports on WHO in 1993 and 2001[3] discussed amply the strengths and weaknesses of the Organization's decentralized structure, and put forward a number of recommendations many of which are still valid.

[1] See http://www1.worldbank.org/publicsector/decentralization/index.asp; JIU/REP/2004/7; JIU/REP/2011/5.
[2] Chapter XI on Regional Arrangements, articles 44, 45, 46, 47 and 52.
[3] JIU/REP/93/2, JIU/REP/2001/5.

I. THE REGIONS

4. The first World Health Assembly defined six geographical areas and authorized the Executive Board (EB) to set up a regional organization for each of them.[4] Since then, the regional structure has remained the same with new additions and minor changes of members from one region to other.

Table 1: World Health Organization regional offices

WHO regional offices	Headquarters	Member States	Country offices
African Region (AFRO)	Brazzaville	46	46
Region of the Americas (AMRO/PAHO)	Washington, DC	35	29
European Region (EURO)	Copenhagen	53	30
Eastern Mediterranean Region (EMRO)	Cairo	22+1	19
South–East Asia Region (SEARO)	New Delhi	11	11
Western Pacific Region (WPRO)	Manila	27	16
TOTAL		194+1	151

Source: WHO Department of Country Focus/HWCO Contact Database as of March 2012. EMRO and Total + 1 include the Occupied Palestinian Territory

5. Although the original assignment of countries to regions was based in the delineation of the regions by the first World Health Assembly (WHA), there are no approved criteria as such for the assignment of countries to regions. The assignment of countries to regions has been based on factors including geographical position, the similarity of health problems, economic aspects, administrative considerations and arrangements made by other international organizations. However, in practice, the deciding factor in certain cases has been the wish of the country concerned.

6. The Inspectors reviewed the composition of the WHO regions and identified the following issues, some of which were the subject of previous JIU reports and are still relevant:

- The arbitrary delineation between the African and Eastern Mediterranean regions, and between the two Asian regions, which is sometimes the source of operational constraints when it comes to dealing with common health issues. It is of note that Algeria and Ethiopia are part of AFRO and not of EMRO, contrary to their neighbours Egypt, Libya, Morocco, Somalia and Sudan. This has similarly occurred with neighbouring countries such as Australia, Indonesia, the Democratic People's Republic of Korea and the Republic of Korea, Malaysia and Papua New Guinea, which have been assigned arbitrarily to SEARO and WPRO;

- The uneven size of the regions. AFRO has 46 Member States and a critical health situation to handle, compared to the two small separate Asian regions (SEARO and WPRO) with 11 and 27 members respectively. Although these regions are heavily populated, having two Asian regional offices is not fully justifiable on the basis of organizational, public health, or economic considerations, as reported to the Inspectors in the course of interviews; and

[4] WHA 1.72 of July 1948.

- The lack of alignment of WHO regions with existing regional groupings at other United Nations system organizations and its impact on how they work together. For instance, Asia and the Pacific is normally one region at the United Nations Development Programme (UNDP), United Nations Educational, Scientific and Cultural Organization, International Labour Organization or Economic and Social Commission for Asia and the Pacific; all African countries are grouped in the Economic Commission for Africa and the African Union, which has instituted the African Union Conference of Ministers of Health. In this regard, the Executive Board special group for the review of the Constitution recommended in 1997 that WHO actively cooperate with the United Nations in its efforts to rationalize the regions across all the specialized agencies.[5]

7. While the Inspectors understand that these anomalies of the present regional structure are not a source of fundamental difficulties in operations, they wish to draw the attention of Member States to the fact that **a redefinition of the current regional design would enhance its operational cost-effectiveness.** Recognizing that this is a highly political issue, **the Inspectors invite the WHO Director-General to undertake consultations with the countries and regions concerned and to seize any opportunity to bring the issue to the World Health Assembly**, which has the constitutional authority to modify the geographical areas.[6]

The case of AMRO/PAHO

8. The existence of the Pan American Health Organization (PAHO) actually precedes by several decades the creation of WHO.[7] Therefore, when the WHO Constitution came into force on 7 April 1948, article 54 dealt with this situation requesting the integration of PAHO within the Organization as soon as practicable. Subsequently, in 1949 an agreement was signed between WHO and PAHO and approved by the Second World Health Assembly.[8]

9. Such integration has not been fully operationalized, although the opinions in this respect diverge depending on whether the interlocutor is from AMRO/PAHO or from WHO. The long and well-established PAHO presence within the inter-American integration system has acted as a centrifugal force, keeping AMRO/PAHO as "a special case" among all other WHO regions. During the interviews with its officials, the special situation of AMRO/PAHO was repeatedly underlined to the Inspectors and presented as echoing the will of Member States of the region.

10. The integration of PAHO into WHO has slowly progressed over the years and an important strategic step was made in 2007, when AMRO/PAHO moved towards aligning its programme of work with WHO. In addition, there are a number of coordination mechanisms by technical area of work, including networks and day-to-day interactions between headquarters and the regional office that work quite well, bringing further integration and coherence.

11. In the area of administration and management, the integration is less evident, although AMRO/PAHO is also active in the Directors of Administration and Finance network and other existing networks in this area. AMRO/PAHO has its own financial and management information system and recently decided to buy an enterprise resource planning (ERP) system at an initial cost of US$20.3 million, in lieu of joining the WHO General Management System

[5] WHO reform: Review of the Constitution and regional arrangements of the World Health Organization: report of the Executive Board special group, EB101/7, para.42.
[6] WHO Constitution, art. 44.
[7] Created in 1902 as the International Sanitary Bureau.
[8] WHA 2.91.

(GSM) at a much lower cost.[9] It also has its own accountability framework, code of ethical principles and conduct, Ethics Office, Internal Oversight and Evaluation Services, administration of justice system and numerous pink pages that highlight within the WHO electronic administrative manual the difference in rules and procedures for AMRO/PAHO.

12. In some of these areas, AMRO/PAHO as a regional office is ahead of the administrative and management practices of WHO headquarters and other regional offices. This has been possible thanks to the high degree of regional autonomy and decentralized decision-making, and to its healthy financial situation, which result from the will of its Member States to make assessed and voluntary contributions to both PAHO and WHO. It has been achieved, however, not without cost in terms of duplication, harmonization and unrealized economies of scale for the Organization as a whole.

13. According to the regional officials interviewed, the above differences do not constitute an obstacle for integration; the flow of information and coordination is continuous and transparent in the administrative areas, and monthly financial reports are sent to WHO which disclose how AMRO is spending resources allocated to it by WHO. Such reports, claimed headquarters officials, are not fully transparent, since they concern only AMRO resources financed from the WHO budget and not the entire resources of AMRO/PAHO. Administratively, AMRO/PAHO is a separate entity. There is therefore no central management oversight of a significant part of the Organization's funds. The implementation reports produced and published by the Organization are incomplete since they do not include the totality of the Organization's financial and staff resources.

14. Overall the Inspectors believe that beyond these issues, the strategic programmatic alignment and the corporate managerial and technical coordination mechanisms in place could be the driver for a further, slow integration of the Americas regional office into the Organization. While the Inspectors respect the sovereign right of Member States of the region to decide and finance administrative and managerial tools for the benefit of the regional organization, they **strongly recommend to further advance the full integration of AMRO/PAHO into WHO. Even if there are cost implications an interface should be created between the new ERP system of AMRO/PAHO under development and the existing GSM at WHO to allow access to real-time data and enhance integration in the area of administration and management.** Actually, the Member States of AMRO/PAHO when approving the modernization of the existing Management Information System have requested that its implementation and "any further upgrades achieve the necessary integration with and provide a similar level of reporting, transparency and accountability than the GSM."[10]

[9] For more details on the ERP system at AMRO/PAHO, see JIU/REP/2012/8.
[10] See CD50.R10.

II. RESOURCE ALLOCATION AND IMPLEMENTATION

Criteria for allocation of resources

15. The principles guiding strategic resource allocation across WHO were outlined in EB 118/7 endorsed by the Executive Board in 2006. A "validation mechanism" was set up to guide allocations, which is made up of: a fixed component to finance the normative and statutory functions of headquarters (28 per cent) and regional offices (15 per cent); a small engagement component for regions that varies according to the number of countries served; and a needs-based component for countries (55–60 per cent) based on gross domestic product and life expectancy adjusted for population size (to ensure that funds are not disproportionately allocated to a small number of populous countries). Out of this formula emerges a series of validation ranges for the seven major offices of WHO; the headquarters range (from 28 to 30.8 per cent) has been used as a rationale to justify the 30:70 ratio for resource allocation between headquarters and regions even if as further recognized it was not based on any real analysis of the functions at each level or of their actual cost.[11] There is however no formula for allocating resources to individual countries.

Allocation of resources between headquarters and regions

16. Since 2006-2007, the 30:70 ratio has been adhered to at the time of planning in all programme budgets. The table below shows the percentage of resources planned for headquarters and regions during the last decade, which indeed confirms that there has been a substantial decline of resources at headquarters level from 54 per cent in 2000–2001 to 31 per cent in 2010-2011 in favour of the regions. Among regions, EMRO and SEARO show the sharpest growth.

Table 2: Planned programme budget distribution of resources between headquarters and regions (in thousands of US$)[12]

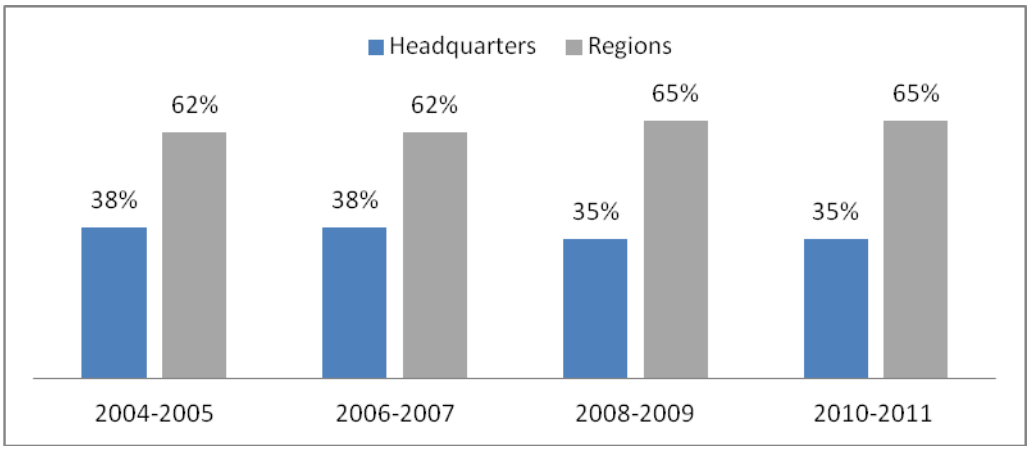
	2000-2001		2002-2003		2004-2005		2006-2007		2008-2009		2010-2011	
	US$	%	US$	%	US$	%	US$	%	US$	%	US$	%
Headquarters	929.9	54%	1028.6	44%	991	35%	993	30%	1175.9	28%	1389.2	31%
AFRO	321.7	19%	530.1	23%	744.7	26%	949.4	29%	1193.9	28%	1262.9	**28%**
AMRO	78.4	5%	87.3	4%	167.2	6%	198.6	6%	278.5	7%	256.1	6%
SEARO	103.4	**6%**	197.7	8%	285	10%	357.3	11%	491.5	12%	544.5	**12%**
EURO	82.6	5%	125.1	5%	158.3	6%	200.6	6%	274.8	7%	261.9	6%
EMRO	97.6	**6%**	226.5	10%	284.4	10%	381.9	12%	465	11%	515	**11%**
WPRO	92.9	5%	130.8	6%	193.5	7%	232.9	7%	347.9	8%	310.3	7%
Total	1706.5		2326.1		2824.1		3313.7		4227.5		4539.9	

17. Yet when it comes to actual resource allocation, the 30:70 ratio has remained aspirational. Regional officials indicated that the process of resource allocation is not transparent and is done without the involvement of the regions.

[11] EB130/5 Add. 1, paras. 26 and 27.

[12] P&B 2000-2001 Financial Report, A55/25; P&B 2002-2003 Financial Report (WHO indicated that the approved budget did not include separate budget amounts for voluntary contributions), A57/20; P&B 2004-2005 Financial Report, A59/28; P&B 2006-2007, Statistical Annexes; P&B 2008-2009, Financial Tables; P&B 2010-2011, Financial Tables. AMRO figures do not include PAHO.

Actual financial allocation between headquarters and regions[13]



18. The gap between resources planned for headquarters and the actual allocation is noticeable, particularly in 2006-2007 (30 per cent planned and 38 per cent allocated) and in 2008-2009 (28 and 35 per cent respectively) although it was reduced in the following biennium (31 and 35 per cent respectively).

Allocation of resources among regions

19. The table below shows the actual distribution of financial resources and staff among regions:

Table 3: Financial and staff resources by region as at 31 December 2011[14]

	Financial resources	Staff
AFRO	**42%**	**45%**
AMRO	6%	3%
EMRO	21%	16%
EURO	**8%**	**10%**
SEARO	13%	14%
WPRO	10%	12%
All regions	100%	100%
Regions	65%	71%
Headquarters	35%	29%

20. AFRO accounts for by far the highest portion of resources (42 per cent) and staff (45 per cent) among all regions, and EURO gets the lowest allocation (8 per cent and 10 per cent respectively). The uneven distribution of resources among regions can be explained by the differences in the number of Member States and country offices, the complexity of the health situation and the local capacity.

Allocation of resources between regional and country offices

21. The same lack of transparency in the actual allocation of resources between headquarters and the regions also applies to the actual allocation of resources to countries, which has been made worse by the absence of criteria and a validation mechanism to distribute funds among

[13] Data for 2010-2011 provided by WHO. AMRO figures do not include PAHO
[14] EB130/5 Add.1 (data for 2008-2009). Data for 2010-2011 provided by WHO. AMRO figures do not include PAHO

countries at the outset of the process. The Inspectors were told during interviews that generally, historical figures constitute the basis for resource allocation to countries. AMRO/PAHO is the only regional office to have a policy for allocating resources at country level, which dates back to 2004 and was recently revised and approved by Member States in September 2012.[15] The new policy also proposes a formula with three components for core funds (a floor or fixed allocation to ensure a minimum country presence, a needs-based component and a results-based component) as well as a percentage of variable funds for initiatives supporting technical cooperation among countries. The policy appears to be quite comprehensive and could be used as a reference by WHO to formulate an Organization-wide policy in the context of the ongoing reform.

Table 4: Financial allocation to regional and country offices in 2010-2011[16]

	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	All regions
Regional Office	24%	46%	27%	**59%**	20%	37%	29%
Country Offices	76%	54%	73%	41%	**80%**	63%	71%

22. The proportion of financial resources distributed between regional offices and country offices varies significantly among regions. EURO records the highest proportion kept for the regional office (59 per cent) and EMRO the highest assignment to country offices (80 per cent).

Allocation of resources among country offices

23. When it comes to the allocation of resources to individual countries, funds are divided very thinly. For about 46 per cent of country offices, the financial allocation was equal to or below US$2 million in the past biennium 2010-2011. Most of these countries are in EURO, WPRO and AFRO.

24. As for staff, the number is so low in some country offices that it raises concerns about how cost-effective such a presence could be. In EURO, 9 country offices (out of 30) and at WPRO, 2 country offices (out of 16) have only two staff or fewer at the end of 2011.[17] The new budget policy at AMRO/PAHO sets a minimum budget allocation to cover a base level of five staff, plus operating costs, in countries that have an official AMRO/PAHO Representative Office.[18]

Table 5: Allocation of resources among countries in 2010-2011

	Number of staff			Financial resources
	≤ 2	≤ 5	≤ 10	≤ US$2 million
AFRO	0	0	4	**11**
AMRO	9	24	26	1
EMRO	**0**	**6**	**15**	6
EURO	**9**	**16**	**24**	**32**
SEARO	0	0	1	1
WPRO	**2**	**4**	**8**	**18**
TOTAL	**20**	**50**	**78**	**69**

[15] CSP28/7 and CSP28.R10.
[16] Data provided by WHO. AMRO figures do not include PAHO.
[17] Data provided by WHO. AMRO figures do not include PAHO.
[18] CSP28/7, para. 32(a).

25. The Inspectors understand the importance for WHO of maintaining a country presence in as many countries as possible. However, such presence should only be maintained when it has the critical capacity in number and qualifications of staff to be effective. Otherwise, it would be more cost-effective to cover such countries from a neighbouring well-established country office or directly from the regional office.

26. **The 2001 JIU report also referred to this issue and called for the completion of the study requested by the Executive Board on the appropriate level of country representation.[19] The Inspectors did not find any evidence of any action taken in this regard. They continue to believe that such a study is necessary**.

27. The Inspectors noted that the prioritization and allocation of resources to regions and countries is at the heart of the reform process and that WHO is working closely with Member States to come up with clear criteria and guidelines. They would therefore **refrain from making any recommendation on this issue and trust that their observations above on the need to ensure a higher allocation to countries and a stronger country office presence be addressed in this process.**

[19] Decision EB 101(6).

III. REGIONAL GOVERNANCE AND MANAGEMENT

A. Regional Committees

28. The Regional Committees are the "supreme" governing bodies of WHO regional organizations. According to Article 50 of the WHO Constitution, the functions of the Regional Committees involve policy formulation of a regional character, oversight of the activities of the regional office, cooperation with other Regional Committees of United Nations organizations and other regional and international organizations, an advisory role on health matters and the recommendation of additional regional appropriations to Governments of the region when the central budget is insufficient, as well as other functions delegated by the World Health Assembly, the Executive Board or the Director-General.

29. While all Regional Committees have the same functions, their rules of procedure differ in terms of membership and attendance, convening of sessions, agenda items, officers of the committee, establishment of subcommittees and nomination of Regional Directors, particularly at AMRO/PAHO and EURO, although in the course of the reform process harmonization on important issues such as the nomination of Regional Directors has been substantially achieved.

30. Additionally, all regions except WPRO have subcommittees that may act as subsidiary bodies of the Regional Committees or have an advisory role to the Regional Director. The number, role and functions of these subcommittees also vary from one region to another. There are subcommittees specifically set up to deal with programme and thematic matters in three regions (AFRO, AMRO/PAHO and SEARO). At EMRO, there are two expert committees which advise the Regional Director on programme and budget issues as well as on health research. At EURO, the Standing Committee has the most comprehensive functions; it deals with programme and budget issues, exercises supervisory functions and prepares decisions for the Regional Committee's meetings. It meets five times a year to ensure continuous intersessional work.

31. The multiplicity of committees and subcommittees at regional level make the governance machinery of the Organization more complex but not necessarily more effective. A more in-depth review revealed that overall, the intersessional work of the regional governing bodies is poor (except at EURO), their oversight of the work of regional offices is weak, and the linkages among them and with the global governing bodies need substantial improvement.

32. Contrary to the global governing bodies, a comprehensive review of the governance of these Regional Committees and subcommittees has not been undertaken until the present reform process. Individually, AMRO/PAHO and EURO have carried out such reviews in 2007 and 2011 respectively, and brought some changes and improvements to the governance process.

33. The Inspectors therefore welcome the review and harmonization of the work of these committees and their rules of procedure initiated within the ongoing reform process which deal with several of these issues and call for their conclusion.

Alignment of regional and global governing bodies

34. A review of the Regional Committees' agendas for the last two years shows that no decision was taken to bring issues to the attention of the World Health Assembly and EB. Instead, all Regional Committees dedicate an agenda item to the World Health Assembly and EB resolutions of interest to the region and other issues proposed by headquarters. The interaction between global and regional governing bodies works only one way. The voice of

the regions is not well articulated and insufficient space is created to have issues discussed first at the regional level and then tabled at the global level. In this regard, it is positively noted that the AFRO group is the most vocal in speaking on behalf of its own region at the Executive Board meetings on specific items. The consolidated document on WHO reform contains forward-looking proposals.[20] The Inspectors call for the implementation of these proposals.

Oversight of regional offices by Regional Committees

35. There is little oversight of the work of regional offices by Regional Committees as required by article 50 (b) of the Constitution. A review of the agenda, decisions and reports of the meetings of the Regional Committees for the last two years shows that management reports are not systematically listed for consideration, and if tabled they generate limited interest and action. For instance at AFRO, other than the annual or biennial report of the Regional Director on the implementation of the programme budget by strategic objectives, there is no other management report tabled for action, and two reports are provided for information on audit and staffing of the regional office. There is not much substantive debate on these reports, and they are adopted or taken note of without a decision or resolution providing direction. WHO officials in the comments to the draft report indicated that the terms of reference of the Programme Subcommittee at AFRO are currently under review, aiming at strengthening the oversight role of the Regional Committee vis-à-vis the Regional Office, among others.

36. Similarly at EMRO, SEARO and WPRO, reporting to Member States is limited to programme budget implementation reports, but unlike at AFRO, resolutions are adopted and at EMRO, such resolutions provide a direction on programme priority setting and resource allocation. At AMRO/PAHO there is an agenda item dedicated to administrative and financial matters. In that region and at EURO, in addition to the annual report of the work of the regional office and the programme budget reports, several management reports are included in the agenda although they do not always generate substantive discussion, decisions or resolutions providing concrete guidance, as per the reports of these meetings.

37. During interviews with regional officials it was reported that oversight and accountability issues generate increasingly more attention at the meetings of Regional Committees, although the concrete modalities for enhancing their consideration are still to be developed.

38. In the view of the Inspectors, the responsibility for the oversight of regional offices is twofold: the **Regional Directors should be more forthcoming and transparent in reporting and tabling financial and management reports for the consideration of Member States; and Member States should better exercise their governance role by requesting the Regional Directors to submit management reports for their consideration and by proposing specific directions and guidance to the Regional Directors on the management of the regional organizations in relevant resolutions and decisions**.

Venue of meetings and participants

39. Article 48 of the Constitution provides that the Regional Committees shall meet as often as necessary and shall determine the place of each meeting. The Inspectors noted that while in most regions the Regional Committees' sessions are held in rotating venues, AMRO/PAHO have organized the meetings at its headquarters in Washington, D.C. during the last decade.

[20] A65/5, paras. 23-27.

40. Rotating venues may be cost neutral for the Regional Offices but not for the host countries, which bear all meeting costs and compensate the Regional Offices for any costs incurred in providing logistical support to the meetings; resources that could rather be channeled to concrete health initiatives. Further, conference facilities and logistics expertise have been created for this purpose at the Regional Offices, which otherwise remain idle. Even if reimbursed, the logistical support which is currently ensured by the Regional Office diverts staff resources from normal operations to ensure the smooth functioning of meetings elsewhere. Finally, rotating venues serve rather to raise the visibility of the host country than WHO and do not contribute to strengthening the working character of the meeting. To summarize, the rotation of the venue of meetings raises concerns about their cost-effectiveness and efficiency. **While the Inspectors recognize that exceptionally there might be other political and practical considerations to be taken into account, as a general rule, they advise abandoning the practice of rotating venues for Regional Committees' meetings.**

41. As for participants at Regional Committee meetings, the Inspectors noted that, at AFRO and EMRO most delegations are represented at the level of Ministers of Health, whereas at AMRO/PAHO and WPRO about two-thirds of attendants are at ministerial level, and at SEARO and EURO about half are ministers. This shows on the one hand the attention paid by health ministries to the regional work of WHO, and on the other hand the challenge for regional offices to have well-prepared meetings and appealing provisional agenda items.

42. The following recommendation aims at enhancing the effectiveness of the governance process at regional level and making it more transparent, consistent and inclusive.

Recommendation 1

The Executive Board should complete, in the context of the current WHO reform process, a comprehensive review of the governance process at regional level and put forward concrete proposals to improve the functioning of Regional Committees and subcommittees and finalize the harmonization of their rules of procedure for the consideration of Regional Committees.

B. Regional management and coordination

43. The highly decentralized nature of the work of regional offices and Regional Directors poses important challenges for WHO to work as "One". While the strong legitimacy of the Regional Directors as elected officials with broad decision-making powers helps to ensure a consistent implementation of decisions within each region, it also represents a challenge for coherence at global level which can only be met through enhanced cooperation among regions and with headquarters. The Inspectors noted an increased readiness of Regional Directors to cooperate with each other and with headquarters management, and the positive assessment they gave of the increasing role played by the Global Policy Group (GPG) in this regard. These developments show that a new improved corporate management style and culture is emerging.

44. The Inspectors also noted that there are no uniform management practices at regional level and that regional strategies, policies and procedures have proliferated either to cover the lack of concrete guidance and standard operating procedures emanating from headquarters, or to complement and adapt those already existing. For instance, AFRO, AMRO/PAHO and WPRO have regional programme strategies; AFRO, AMRO/PAHO and SEARO have their own resource mobilization strategy; AFRO has a Partnership Strategy; EMRO has a

knowledge management strategy; and SEARO has an information and communications strategy.

45. **The investment in preparing these strategies and policies is considerable. The Inspectors therefore suggest that they be formulated only when no global strategies exist, or there is a need to substantially modify them to be adapted to regional conditions, and if so in consultation with headquarters and other regions to build on the experience gained by others, avoid duplication and ensure coherence across the Organization.**

46. Regional Directors have put in place their own management coordination and decision-making mechanisms, including regular meetings of senior managers and advisory groups and committees, to assist them in discharging their management responsibilities. A better exchange of information among the regions on these management practices would be useful.

47. However, as shown by the results of the JIU survey below, coordination and cooperation within the regions should be improved, particularly in some regions.

Question 18: I think there is sufficient coordination and cooperation within clusters/divisions/units at the following levels:

Answer options	AFRO	AMRO	EMRO	EURO	SEARO	WPRO
Yes	25.8%	24.5%	21.0%	31.3%	30.1%	30.0%
Somewhat	40.6%	51.1%	45.0%	46.6%	43.8%	46.3%
No	**20.6%**	19.4%	**28.0%**	19.1%	**21.9%**	18.8%
No opinion	12.9%	5.0%	6.0%	3.1%	4.1%	5.0%

Structure of regional offices

48. A review and comparison of the respective organizational charts disclosed that the structure of regional offices in terms of divisions/clusters/areas is organized around the priority areas and strategic objectives identified in the Medium-term Strategic Plan (MTSP) and biennial programme budget, although they do not necessarily mirror them. There are some similarities and differences between the structure of headquarters and the regional offices, and among the six regional offices, with only one organizational area common to all, namely Health systems.

49. Some regional offices, such as EMRO and EURO, have modified their structures to better align them with headquarters, in an attempt to facilitate interaction and coordination. Notwithstanding the specific needs of each regional office, **the Inspectors encourage the harmonization of structures that would better serve the purpose of working together as "One".**

Delineation of responsibilities among the three levels

50. Article 2 of the WHO Constitution outlines the functions of the Organization as a whole. However, there is no corporate document that articulates from a programmatic and operational point of view what is to be done by whom at which level, and how the three levels of the Organization should work together to complement each other and interact to create further synergies and avoid duplication.

51. This was acknowledged in various reform documents which refer to the need for better alignment – coherence, hierarchy and synergy – and division of labour between global and

regional levels in support of countries,[21] and which propose to better define the roles and responsibilities of the three Secretariat levels and create standard operating procedures to facilitate collaboration and joint work. A table indicating the roles and responsibilities by level in six areas of work has been developed, which was considered by officials interviewed and Inspectors to be a good basis from which to clarify the division of labour.[22]

52. At the regional level, EURO has produced a document which was considered by the Regional Committee in its session of September 2011 with a matrix that brings together the different regional office organizational structures and functions specifying who does what and assigning a level of responsibility to each.[23] **The matrix appears to be quite comprehensive and with some adjustments could be used by other regions and even at global level,** based on agreed functions and levels of responsibility.

53. The Inspectors found in the course of their interviews with WHO heads of technical clusters/areas in regional and country offices that overall they have a clear understanding of the division of responsibilities among the three levels. The problem is that in practice, this division of responsibilities is sometimes by-passed by the actions of headquarters' clusters, creating friction. Although it is recognized that there has been a noticeable improvement in recent years, there are still instances where clusters in headquarters, instead of playing a back-up role, take the lead in brokering and providing technical cooperation, a role that normally should be reserved to countries with the support of regions.

54. Administrative functions have been redesigned at the three levels with the introduction of the GSM. The efficiency and effectiveness of such a design, its actual functioning and required improvements are discussed in Part I (JIU/REP/2012/6).

55. Fifty-seven per cent of respondents to the survey indicated that they have a clear idea about the division of responsibilities in their area of work, and for 31 per cent it is "somewhat" clear. Opinions vary across regions.

Question 19: I have a clear idea about the division of responsibilities in my area of work between HQ, the regional offices and the country offices.

Answer options	TOTAL	HQ	AFRO	AMRO	EMRO	EURO	SEARO	WPRO	CO
Yes	57.0%	52.5%	**60.0%**	**70.5%**	**51.0%**	**59.5%**	**68.5%**	**61.3%**	**57.0%**
Somewhat	30.8%	33.0%	27.7%	20.1%	32.0%	29.8%	26.0%	32.5%	33.6%
No	10.0%	11.1%	11.6%	7.2%	16.0%	9.2%	5.5%	6.3%	7.5%
No opinion	2.2%	3.4%	0.6%	2.2%	1.0%	1.5%	0.0%	0.0%	2.0%

Coordination and cooperation among the three levels

56. At global level, several tools and coordination mechanisms have been set up and their work has been made formalized, such as meetings of the management and administration networks, technical networks by area, and the biennial global meetings of heads of country offices with the Director-General and Regional Directors. Generally, these networks operate better between headquarters and regions than between regions and countries. At regional level they are not always effectively reproduced between regions and countries. A good example of coordination mechanisms are the regional meetings of heads of WHO country offices.

[21] EBSS/2/INF.DOC./3; EBSS/2/INF.DOC./5; EBSS/2/2.
[22] A65/5, pp. 16 and 17.
[23] EUR/RC61/16 "Coherence of the Regional Office's structures and functions", p. 12.

57. Most heads of technical departments in regional offices interviewed would like to have more regular contact with headquarters' technical clusters, whereas in some areas, such as HIV/AIDS and polio, contact was considered to be good.

58. It was also noted that the regular network meetings with country offices in the different administrative areas have been affected by resource constraints. **The Inspectors are concerned with the impact that not holding these meetings may have on capacity-building and effective delivery at country level, and recommend that other options be explored.**

59. To promote coordination and communication across the three levels of the Organization in support of the work of WHO at country level, Guidelines for Working with WHO Country Offices were developed in 2006 and have been recently revised. They regulate the country visits of WHO staff from headquarters and regional offices as well as the invitations to nationals of countries and the signing of contracts/agreements with national institutions and individuals. All six regions have reported cases of non-compliance with these guidelines to the Department of Country Focus (CCO) at headquarters, but the number of non-compliance cases has been reduced substantially over the years.

60. The majority of the respondents to the survey are of the opinion that the level of coordination and cooperation between the three levels of the Organization is adequate or somewhat adequate. Still, coordination and cooperation needs to be further strengthened, especially between headquarters and regional offices, as 23 per cent of respondents think that coordination and cooperation is inadequate. This figure is even higher at headquarters.

Question 20: I think the level of coordination and cooperation between the following WHO entities is adequate:

Answer Options		TOTAL	HQ	AFRO	AMRO	EMRO	EURO	SEARO	WPRO	CO
WHO Headquarters and regional offices	Yes	16.0%	11.3%	18.7%	13.7%	23.0%	19.1%	23.3%	10.0%	21.5%
	Somewhat	43.9%	45.4%	41.3%	46.0%	46.0%	42.7%	50.7%	58.8%	38.4%
	No	**22.7%**	**33.2%**	14.2%	25.2%	9.0%	28.2%	15.1%	17.5%	8.8%
	No opinion	17.4%	10.1%	25.8%	15.1%	22.0%	9.9%	11.0%	13.8%	31.3%
Regional offices and country offices	Yes	28.2%	9.5%	43.9%	38.8%	31.0%	44.3%	32.9%	40.0%	39.1%
	Somewhat	41.7%	32.2%	44.5%	46.0%	56.0%	46.6%	58.9%	46.3%	46.9%
	No	10.0%	13.0%	6.5%	9.4%	7.0%	3.1%	5.5%	12.5%	10.4%
	No opinion	20.2%	45.2%	5.2%	5.8%	6.0%	6.1%	2.7%	1.3%	3.6%

61. The following recommendation aims at enhancing coordination and cooperation across the Organization.

Recommendation 2

The Director-General, in consultation with the Assistant Directors-General and Regional Directors, should monitor the set-up and functioning of networks and annual meetings by technical and administrative areas of work at the three levels of the Organization.

C. Regional Directors

62. Article 52 of the Constitution provides that the "head of the regional office shall be the Regional Director appointed by the Board in agreement with the regional committee". As such, Regional Directors are elected officials like the Director-General. However, in the organizational chain of command, they are under his/her authority as per article 31 of the Constitution, which stipulates that the Director-General is the chief technical and administrative officer of the Organization, and article 51, which indicates that the regional offices are subject to his/her general authority.

63. The two previous JIU reports on WHO examined this issue and its implications in detail. Particularly, JIU/REP/93/2 highlights that accountability is better exercised when based on a single, pyramidal chain of command and not with seven "executive heads". It proposes to change the procedures for nominating Regional Directors – without changing the Constitution – to empower the Director-General to select them and nominate them for confirmation by the Executive Board, following consultations and in agreement with the Regional Committees. While the Inspectors concur with this analysis, they are of the opinion that the involvement of the Director-General in the selection process of the Regional Directors is not the only way to improve the chain of command and enhance accountability and ensure coherence.

64. The current Director-General indicated to the Inspectors that she has opted for concentrating her efforts in promoting teamwork and creating a corporate culture of "One WHO". The Inspectors are of the view that the increasing role of the GPG and the existing possibilities for the Director-General to strengthen the accountability of senior management, will enable the Director-General to exercise his/her prerogative as chief technical and administrative officer without changing his/her role in the selection process of Regional Directors (see para. 25 of Part I of the present report (JIU/REP/2012/6) and para. 74 below).

65. The WHO reform document contains proposals to revise and harmonize the procedures for nominating Regional Directors in line with the process for nominating the Director-General,[24] based on the principles of fairness, transparency and the personal qualifications of candidates.[25] The Inspectors endorse these proposals.

Delegation of authority and accountability

66. The backbone of effective decentralization is the transfer of delegation of authority and decision-making power, and the assignment of accountability and responsibility for results, to officials at all levels of the Organization. The last delegation of authority from the Director-General to Regional Directors dates back to 2008, and accords extensive powers to them in programme implementation, management and administration. All Regional Directors enjoy the same degree of delegation of authority and they are all generally satisfied with the extent of authority delegated to them.

67. The Inspectors note the high degree of delegation of authority in the area of human resources, which goes beyond existing practices at many other United Nations system organizations. In contrast, the Inspectors found that despite the fact that regional and country offices are increasingly involved in resource mobilization such delegation of authority does not explicitly cover resource mobilization and the use of resources locally mobilized, although they have the authority to sign donor agreements.

68. Regional Directors can in their turn delegate the authority entrusted to them to senior officials at the regional office and to heads of WHO country offices. The extent of authority

[24] See A65/5, para. 30.
[25] See JIU/REP/2009/8.

delegated to managers in regional and country offices varies across the regions. Unlike at the Director-General level, there is no consistent approach in delegating authority by Regional Directors. In the area of procurement for example, at AFRO and WPRO, regional heads have the same delegated authority as country heads, whereas at EURO it is higher for regional heads, and at SEARO it is lower than for country heads. It is to be noted that the perception of staff about how clear and well documented the delegation of authority is varies greatly among regions, as shown by the table below.

Question 21: I think the delegation of authority for work processes among divisions and/or departments is clear and well documented.

Answer options	AFRO	AMRO	EMRO	EURO	SEARO	WPRO	CO
Yes	**41.9%**	36.7%	33.0%	26.7%	27.4%	38.8%	36.5%
Somewhat	35.5%	**37.4%**	**35.0%**	**44.3%**	**56.2%**	**47.5%**	**40.7%**
No	18.1%	20.1%	27.0%	21.4%	12.3%	11.3%	16.6%
No opinion	4.5%	5.8%	5.0%	7.6%	4.1%	2.5%	6.2%

69. The delegation of authority to Regional Directors states that they are accountable to the Regional Committees for the effective and efficient operation of the regional offices and to the World Health Assembly through the Director-General for the efficient and effective use of resources in implementing the programme budget within the region under their responsibility. They have therefore a dual accountability to Member States and to the Director-General.

70. The delegation order also indicates that compliance will be monitored systematically and withdrawal of the authority delegated will be considered in the case of non-compliance. It also announces some work to establish an accountability framework for monitoring and harmonizing delegation of authority across the Organization, of which the Inspectors did not find any evidence.

71. The JIU survey disclosed wide variances among regions in the perception of staff about the accountability of managers.

Question 23: I think managers are held accountable for the authority delegated to them.

Answer options	AFRO	AMRO	EMRO	EURO	SEARO	WPRO	CO
Yes	**52.3%**	**33.1%**	34.0%	**37.4%**	**45.2%**	**42.5%**	**51.5%**
Somewhat	20.0%	33.1%	**40.0%**	31.3%	31.5%	38.8%	32.9%
No	14.8%	28.1%	22.0%	23.7%	16.4%	12.5%	9.8%
No opinion	12.9%	5.8%	4.0%	7.6%	6.8%	6.3%	5.9%

72. In its 2011 report on accountability frameworks in the United Nations system (JIU/REP/2011/5), JIU emphasizes the need to create a culture of accountability within the Organization, accountability which should be applied at all levels from the top down; executive heads and the heads of major organizational units should be therefore the first to be held accountable for the results that they are expected to deliver under the principle of "leading by example". According to that report, the existing accountability tools are work plans and performance assessment.

73. At WHO, both accountability tools exist, but Regional Directors are not subject to a formal performance assessment. The Director-General indicated that she is not the first-level supervisor of Regional Directors by means of the Constitution, but she provides feedback to

them on their performance. The Inspectors are not aware of any performance appraisal of Regional Directors done by Regional Committees either.

74. The **Inspectors encourage the Director-General to establish monitoring and accountability mechanisms for Regional Directors to monitor compliance with the authority delegated to them and to assess their performance.** As chief technical and administrative officer of the Organization, the Director-General has the constitutional authority and duty to do so, regardless of the dual reporting line of Regional Directors. **The United Nations senior management compact and the UNDP balanced scorecard are good practices in this respect and should be taken into account.**

IV. COUNTRY OFFICES

75. Unlike regional offices, there are no provisions in the WHO Constitution concerning the set-up of country offices.[26] In fact, there are no such criteria at global level.

76. WHO has the biggest network of country offices of all United Nations specialized agencies. There are currently 151 country offices, 11 more than at the time of the previous JIU report in 2001. In chapter II above, the report refers to the WHO presence in some countries in terms of resources allocated (financial implementation and staff), and the need to define the criteria for a minimum and more robust country presence while serving some countries from an established office in a neighbouring country office or from the regional office.

77. Of the 151 WHO country offices, 30 per cent are in AFRO, where there is one country office per Member State. In other regions, there is not necessarily a physical WHO presence in each Member State. In total, 15 Member States (8 per cent of the total) are served by a nearby country office in AFRO, AMRO/PAHO and WPRO.[27] The arrangements in place in countries where no office exists vary from one region to the other.

78. Efforts to decentralize are aimed at getting closer to end beneficiaries. In many instances, besides the main WHO country office, there are also sub-offices. Sub-offices have been established in large, federated countries and in countries in crisis situations in all regions. In 2012, 137 sub-offices existed under 39 country offices (26 per cent of the total).[28] Other United Nations system organizations involved in emergencies also have sub-offices close to the heart of operations, or mobile teams that provide assistance on a rolling basis according to needs. In the Inspectors' view, **the need to maintain sub-offices should be constantly re-assessed based on established criteria, and the deployment of mobile teams considered as an alternative given the difficult operating conditions in some areas.** Procedures should also be developed to wind up operations and close sub-offices, based on the experience gained by humanitarian organizations. In setting up country offices and sub-offices, the presence of other United Nations and non-United Nations organizations partners in health should be taken into account.

79. The following recommendation aims at enhancing the effectiveness of the WHO country presence.

Recommendation 3

The Director-General and Regional Directors, in consultation with Member States, should agree on criteria for a minimum and robust country presence. Criteria and procedures should also be developed to open and close sub-offices subject to changing needs.

Country support offices

80. At headquarters and regional offices, specific units or functions provide support to countries and constitute a network. There is no coherence in the titles or set-up of these offices across regions, or their location and reporting lines.

[26] Country Offices in this context refers to "WHO Offices in Countries, Territories and Areas".
[27] Data provided by the WHO Department of Country Focus.
[28] Ibid.

81. At headquarters, the Department of Country Focus (CCO), which supports WHO work in all countries, is (mis)placed within a technical cluster, the Health in Crisis Cluster. In fact, its location, reporting line and management have changed frequently in the last five years; it lacks stability and empowerment. At the regional offices there are country support units (CSUs) in four regions, whereas at EMRO and SEARO it is a function within programme planning and management with different reporting lines. In the view of the Inspectors it is at AFRO, AMRO/PAHO and EURO where these units are best situated strategically, as separate offices with a direct reporting line to the Regional Director.

82. The staffing of CSUs also reflects the strategic importance assigned to their respective work.

Table 6: Professional staff at country support units/functions and countries supported as at 31 December 2011[29]

	Ratio staff/ countries supported
AFRO	**3/46**
AMRO/PAHO	6/29
EURO	3/30
EMRO	**1.5/19**
SEARO	**0.5/11**
WPRO	2/15
Headquarters	8/6

83. The functions of the headquarters office has evolved from its establishment in 2001 with a more operational role providing central backstopping for fragile countries and countries in crisis to date where it has a more normative and convening role. A major outcome of its work has been the introduction of Country Cooperation Strategies (CCSs). **The operational role of the Department of Country Focus at headquarters should be left to the regions and reduced to a minimum. Emphasis should be put on monitoring work in addition to normative work, aiming at harmonizing practices and creating synergies among regions and the work of the different country support units/functions.** Its normative work should include, inter alia, the development of guidance for: country presence, the setting up and closing of offices, the categories of countries and types of head of country offices, the selection of heads of country offices, delegation of authority to heads of country offices and intercountry, interregional and inter-organizational coordination and cooperation at country level. Their monitoring work should include the analysis of systemic issues in CCSs and the performance of countries, heads of country offices and country support offices.

84. The Department of Country Focus at headquarters should monitor the work of country support units and assist them in enhancing their capacity, and bringing their performance to the same level. To this end, **a common set of objectives and indicators specific to the work of these offices should be set up and their achievement monitored**. **It is also necessary to conduct an evaluation of the work of the country support function at headquarters and regional levels.**

85. The country support units in regions carry out a variety of tasks and their performance varies. Among the six regions, the weakest country support function was found at EMRO and SEARO; their location within the office, role and staffing need to be reviewed. In common,

[29] Data provided by WHO. Headquarters has two posts vacant. Support may be also provided to countries and territories in the region which do not have an office.

they serve as a communication channel between the regional and country offices, coordinate the elaboration of CCSs, collect and summarize the reports of Heads of WHO Country Offices (HWCOs), organize the HWCO meetings and support intercountry and interregional cooperation, the United Nations Development Assistance Framework (UNDAF) process and the United Nations coordination mechanisms. In some regions, **the Inspectors noted the excessive reporting obligations of country offices to country support units which were unable to duly process the incoming information. Due consideration should be given to streamlining the reporting system of HWCOs.**

86. Officials from country offices visited gave positive feedback regarding the operation of the country support units at regional offices, especially of their role as a channel of communication and broker of assistance. Positive feedback was also provided about the functioning of the CSU network created in 2003 as a forum for dialogue and learning among the seven country support units/functions with periodic virtual communications and meetings. **In the view of the Inspectors, the network should take a step forward to leverage its role in harmonization and decision-making, bringing concrete proposals for inclusion in the agendas of the GPG and Directors of Programme Management meetings.**

87. The following recommendation aims at enhancing the effectiveness of the seven country support units/functions across the Organization.

Recommendation 4

The Director-General and Regional Directors should take action as appropriate to reposition the country support units/functions at headquarters and regions more strategically, enhance their capacity and leverage their role in harmonization and decision-making.

Country Cooperation Strategies

88. The Country Cooperation Strategy (CCS) is the key strategic instrument in WHO for its work in and with countries, in support of a country's national health policy, strategy or plan. It serves to harmonize and position WHO cooperation in countries with that of other United Nations and development partners, based on its core functions and comparative advantage.[30] The CCS is developed through consultations and strategic dialogue with key stakeholders.

89. There are today 116 CCSs and two multi-country cooperation strategies, covering in total 142 out of 151 countries with a physical WHO presence, in all regions except EURO. They have a 4- to 6-year cycle and most of them have been revised/updated. EURO has started developing CCSs recently, including in countries where there is no office.

90. The relationship between the CCS and other WHO planning instruments is weak, as acknowledged in the different reform documents. While the CCSs can provide an indication of individual country priorities, "the development process is imperfect and the link with the WHO managerial framework and country programme budgets in particular, is weak";[31] and "there is no systematic link between the priorities identified in the country cooperation strategies and the categories around which the programme budget is organized. As a result, there is a mismatch between the country cooperation needs that are expressed in the country cooperation strategy and the programme budget that is approved".[32] To bridge this gap, the

[30] See WHO Country Cooperation Strategies Guide 2010.
[31] See EB30/5 Add.1, para. 10.
[32] See WHO Reform: Meeting of Member States on programmes and priority setting. Document 1 of 20 February 2012, para. 35.

strategic agendas of the CCSs were recently mapped to the strategic objectives of the MTSP, and the results used to inform the preparation of the draft twelfth General Programme of Work (GPW) and the 2012-2013 Programme Budget from the bottom up.

91. The JIU review of a sample of CCSs confirmed the lack of linkage with major WHO strategic planning instruments. In addition, more corporate branding, consistency and regularity in their preparation is required. Their layout differs, including within some regions, even if they follow to a certain extent the structure proposed in the guidelines, and in content their quality is uneven. More importantly, in some instances there is a gap (which may range from one to five years) between the two generations of CCSs.

92. In the view of the Inspectors, the use of CCSs in the WHO planning process should be further enhanced to better reflect country priorities and needs. Likewise, the previously mentioned mapping of existing CCSs has informed the planning process at global level; a similar process should be carried out at country level when work plans are prepared.

93. Finally, a major weakness of the CCSs themselves is that their implementation is not monitored and reported on properly. The revised CCS Guide developed in 2010 includes for the first time guidance to review WHO performance in countries. This review should in principle be conducted during the second half of the CCS cycle and used in the development of the revised CCS for the next cycle. **It is recommended that the Department of Country Focus at headquarters and the respective country support units/functions at regional level guide this review process to ensure coherence across the Organization.**

Heads of Country Offices

94. HWCOs are designated by the Director-General and the respective Regional Directors to manage the WHO core functions at country level and provide leadership in the key functional areas: advocacy, partnership and representation; support to policy development and technical cooperation; and administration and management.[33]

95. Currently, there are too many different types of HWCOs: WHO Representatives (WRs), Heads of Country Office (HOCs), Liaison Officers (LOs) and others:[34]

Table 7: Heads of WHO Country Offices

Regions	**Heads of WHO Country Offices**				**Total**
	WRs	**HOCs**	**LOs**	**Other**	
AFRO	43	-	3	-	**46**
AMRO/PAHO	27	-	-	2	**29**
EURO	8	21	-	1	**30**
EMRO	18	-	-	1	**19**
SEARO	11	-	-	-	**11**
WPRO	10	-	5	-	**15**
Total	**117**	**21**	**8**	**4**	**150**

96. **In the view of the Inspectors, the existing types of HWCOs should be rationalized. Whenever the head of a WHO country office has an operational role in addition to a representation role, he/she should be always given the title of WHO Representative**

[33] Roles and functions of Heads of Country Offices require competencies endorsed by the GPG.
[34] Data provided by the WHO Department of Country Focus. There is currently no HWCO in the Republic of Korea.

(WR) and all should be appointed by the Director-General, in consultation with the relevant Regional Director, following the established selection process. The difference among HWCOs should be in their grades (P-6 or P-5) according to the complexity of the country operations and the qualifications and experience required.

97. By category, the majority of HWCOs (84 per cent) are international Professional staff and 16 per cent are National Professional Officers (NPOs), mostly in EURO.[35] The appointment of NPOs as heads of country offices is an issue of concern for the Inspectors, since as nationals in their respective countries of origin, they could be subject to conflicts of interest and their independence could be questioned. **The Inspectors recommend that the practice of assigning NPOs to head operations of country offices be gradually discontinued, even if it is more costly to appoint international staff.**

98. By grade, most HWCOs are P-5 or P-6 (42 and 47 per cent, respectively) and only a few are D-1 and D-2 (9 and 2 per cent each).[36] Indeed, at EMRO most HWCOs have the same grade. **It is recommended that HWCO positions be re-classified according to the complexity of the country situation and the relevant managerial experience required.** The Office of Human Resource Management at headquarters should be involved in the re-classification exercise to ensure consistency across the Organization.

99. By gender, only 34 per cent of HWCOs are women. The highest gender imbalance was found in WPRO, with a ratio of 5.5:1 male to female, followed by EMRO with 4.0:1 and AFRO with 3:1. Overall, the trend has improved moderately in the last five years, particularly at WPRO.[37] Further **efforts should be made to improve gender balance.**

100. Mobility practices of HWCOs differ among regions. Mobility is mostly exercised within regions and with different time limits. According to the figures provided, 17 per cent of HWCOs have been in their current position for more than five years. Most reassignments are within the region; only 21 per cent of HWCOs originate from a country outside the region where they are posted; the proportion is extremely low at EURO and AFRO (0 per cent and 5 per cent, respectively). About 7 per cent of HWCOs were previously posted at headquarters and 42 per cent came from a regional office.[38]

101. **A mobility policy for HWCOs should be designed and implemented across the Organization, whereby in the interests of cross-fertilization, a maximum number of years for rotation is set up (by category of duty station and among regions and at headquarters). Such a policy should be approved by the GPG and the regions should abide by this policy; implementation and exceptions should be monitored and reported to the GPG and the governing bodies in the context of the regular human resources annual report.**

102. Heads of country offices are at the forefront of organizational performance, hence the quality of their selection process is crucial. The previous JIU report expressed concern about the competencies of WHO representatives in programme and human resources management and media relations, and proposed that relevant training courses should be organized.

103. Notable progress was identified in the process of selecting and training heads of country offices. A Global Roster of internationally recruited HWCOs was launched in 2010. Assessment centres evaluate serving heads and candidates to this position against a set of key professional and managerial competencies and a review panel decides on the candidates to be

[35] Ibid.
[36] Out of 102 international professionals. Data provided by WHO Department of Country Focus.
[37] Out of 130 designated HWCOs. Data provided by WHO Department of Country Focus.
[38] Data provided by the WHO Department of Country Focus.

placed on the roster. The Inspectors received positive feedback about the improvements in this selection process.

104. The process is, however, subject to further improvement. During the course of this review a working group was looking at a number of critical issues identified, which include the need for greater diversity in the roster, particularly in gender, language skills and younger candidates, and the need to encourage rotation and mobility, through a target of 30 per cent for transfers outside the region and through lateral transfers without advertising vacant posts.

105. **The Inspectors welcome these initiatives which address to some extent their observations above on gender and mobility. However, they reserve their opinion as to the appropriateness of authorizing transfers of serving HWCOs within regions without advertising the posts. It may defeat the purpose of increasing mobility outside the region and the effective use of the global roster, and does not best serve the principles of competitiveness and transparency in the selection of staff.**

106. As recommended in the previous JIU report, efforts have been made to identify specific learning opportunities for HWCOs and resources have been allocated to this purpose. The current HWCO Orientation and Development Programme includes two major training activities in a course organized by the United Nations System Staff College, and an online course in global health diplomacy, under development, in addition to other existing training opportunities at regional level.

107. The participation in these learning opportunities, however, is still modest. At AFRO, for instance, only about one quarter of serving HWCOs have undergone such training at global level, and another quarter at regional level, mostly after taking up their functions. **In the view of the Inspectors, such training should be mandatory for all serving HWCOs**.

Delegation of authority and accountability

108. If decentralization at WHO means getting closer in its support to countries, then heads of country offices should be empowered to take decisions expeditiously to better serve country needs, particularly in countries in crisis and in emergencies. As such, relevant individual delegations of authority should take into account the complexity of the country operations and the capacity of the country office.

109. In view of the above, the Inspectors found that the extent of **current delegations of authority to heads of country offices is satisfactory overall, but should be expanded in some areas, such as human resources, procurement and travel, and better tailored to specific country situations.**

110. The delegation of authority to heads of country offices is administered at each region by the Regional Director and as a result the delegated authority varies from one country/region to another for the different types of country heads. It varies both in form (general administrative instruction or individual delegation orders) and more importantly in content (areas covered and ceilings/thresholds applied).

111. For instance, in terms of form, AMRO/PAHO uses individual delegation orders while other regions use general instructions. As for areas covered, they include programme management, financial management, procurement, human resources, and the signing of agreements with different extents and details. The most relevant exceptions were found at SEARO, where resource mobilization is also included, and at AMRO/PAHO and AFRO, where human resources is excluded (centralized at regional level) or has been temporarily suspended, respectively. As for thresholds, in procurement they vary across regions within a large range from US$25,000 to US$100,000.

112. Within each region, however, the delegation of authority is the same to all heads of country offices, except at SEARO, which has three tiers of countries with different procurement thresholds, and at AMRO/PAHO, where one country (Brazil) has a higher procurement ceiling. As such, they do not take into account the differences among country offices in terms of their size, capacity and operational needs. **In the view of the Inspectors, in large country offices where administrative capacity exists, a higher delegation in recruitment and procurement should be envisaged. Similarly, in countries in crisis situations or emergencies which are covered by Standard Operating Procedures for emergency situations, a higher delegation may be justified. Another potential area of further delegation is the approval of duty travel of staff within the approved work plan and budget**.

113. Further, within each country office the heads of office should delegate authority to managers to perform some administrative and programmatic functions. Currently, it exists only at countries in three regions and is limited to procurement (at EMRO, EURO and WPRO).

114. To conclude, as stated in the case of the authority entrusted to Regional Directors, **mechanisms should also be put in place to monitor the delegation of authority to heads of country offices and further down in the vertical chain of command to hold them accountable for their actions**. It is to be noted that respondents to the JIU survey from country offices gave higher ratings than the regional offices to the question (number 23) of whether managers are held accountable for the authority delegated to them (with 52 per cent answering "yes" and 33 per cent "somewhat").

115. The following recommendation aims at enhancing the effective management of the Organization.

Recommendation 5

The Director-General, in consultation with the Global Policy Group, should revise the existing categories, grades and delegation of authority of heads of country offices in line with the size, capacity and operational needs of the country offices.

V. INTERREGIONAL, SUBREGIONAL AND INTERCOUNTRY COOPERATION

116. Neighbouring countries and countries in different regions with cultural links or similar geographical conditions may have similar health patterns and face similar health challenges. Countries grouped across regions with common interests within regional integration mechanisms with established strategies and agendas also play an important role in implementing health programmes. WHO should leverage them to enhance intercountry and interregional cooperation in health.

117. The Inspectors noted that some regional offices have undertaken modest intercountry initiatives and even some interregional cooperation initiatives. The most notable are the networks of small island developing States, BRICS countries (Brazil, the Russian Federation, India, China and South Africa), Mekong countries, the ePORTUGUESe network and the AMRO/PAHO support to the polio eradication programme in AFRO countries.[39]

118. However, currently, with some exceptions these interregional cooperation activities are not planned, financed and pursued in biennial programme budgets and work plans. The inflexible budgetary planning and reporting system rather impedes the financing and implementation of any such initiatives even though they are not necessarily expensive.

119. The country support units at headquarters and in some regions have played an important role in facilitating such exchanges and should continue to do so. But, **at corporate level, there is a need to design a strategy, allocate resources and define roles and responsibilities. Country offices should be called on to identify potential areas of cooperation within the specific country needs**. **Regional offices should set up mechanisms to disseminate knowledge within the region and play a role in matching needs with capacity in other countries within the region or outside the region, and in bridging provider and recipient countries in mutually beneficial arrangements.**

120. The need to allocate funds for intercountry collaboration has been acknowledged at different levels of the Organization in various documents and in the course of interviews with WHO officials. The reform papers also call for a shift from "vertical hierarchy to horizontal networking" which will entail a "growth in the relationships between regional offices, and between groups of country offices within and across regions".[40]

121. The following recommendation is aimed at enhancing intercountry and interregional cooperation and coordination.

Recommendation 6

The Director-General and Regional Directors should include in their programme budgets and work plans specific objectives, activities and indicators relating to the promotion of intercountry and interregional cooperation and ensure that adequate funding is foreseen for their implementation.

Decentralized regional and subregional programmes at AMRO/PAHO

[39] See EB130/5 Add.7.
[40] EBSS/2/2, para. 114.

122. AMRO/PAHO has gone further in bringing assistance closer to country needs; it formally approved in 2004[41] a Regional Programme Budget Policy which formalized the subregional level of technical cooperation and established the subregional programme with a subregional presence around four subregional technical cooperation programmes that provide technical cooperation in coordination with subregional integration mechanisms in the Caribbean, Central America, Andean countries and the Southern Cone.

123. These subregional programmes have their own specific budget, staff and structures, which account for 7 per cent of the regular budget of AMRO/PAHO. The Country Focus Support Unit in the regional office monitors the implementation of the budget and subregional staff and coordinates the preparation of the technical cooperation work programme based on subregional priorities. Regional and subregional advisors by area have been posted to existing country offices. Subregional meetings are organized annually to discuss issues of common interest. At the time of the Inspectors' review, all together there were some 50 regional and subregional advisors (who provide technical assistance) and 15 focal points (who are responsible for planning and reporting) spread out among more than 20 countries.

124. The Inspectors consider this regional and subregional decentralized presence as an attempt to bring more cost-effective assistance closer to needs and promote South-South cooperation.[42] They were, however, not in a position to conduct an in-depth assessment of its efficiency and effectiveness from both a substantive and administrative point of view. They noted that **no independent evaluation of this initiative has yet been conducted and recommend doing so**.

Intercountry support teams at AFRO

125. The setting up of intercountry support teams (ISTs) in Africa is another regional initiative to bring more cost-effective assistance to countries, which dates back to 2005. The creation of these teams is the backbone of the AFRO strategy to strengthen support to countries.

126. Three ISTs are deployed in Harare, Libreville and Ouagadougou covering, respectively, 18 eastern and southern African countries, 11 central African countries and 17 western African countries. The smallest of these ISTs covers as many countries as SEARO and the largest as many as WPRO.

127. The ISTs are not a hierarchical structure within AFRO; they are an extension of the regional office, being decentralized/delocalized structures to facilitate regional operations and capacity-building. As such, their budget (staff and operating costs) is financed by the regional office. Operational guidelines were developed in 2008 that describe their roles and responsibilities and programmes covered. The creation of the ISTs entailed a redefinition of the roles and responsibilities of technical clusters in AFRO to focus primarily on developing norms and standards, policies and strategies, and generating and disseminating evidence.

128. The ISTs have their own work plans and activities to contribute to the delivery of planned office-specific expected results and are responsible for monitoring and reporting in the GSM, with clear delegation of authority from the Regional Director to the IST coordinators.

129. The functioning of ISTs was evaluated recently by a mixed team of internal and external evaluators, including a KPMG staff in April 2012. The evaluation overall was quite positive but reported findings relating to: inadequate joint planning with country offices; imbalances in the quality of support to countries with the accent placed on host countries; delayed

[41] Adopted by the 45th Directing Council.
[42] See JIU/REP/2011/3.

feedback and lack of a tracking mechanism for incoming requests; and the need to improve communication and cooperation with other ISTs, Ministries of Health, United Nations agencies, and partners outside the host country. In terms of staffing of ISTs, the evaluation indicated their expertise as high quality but insufficient in number, identifying gaps by IST and by area, although some consultants hired had either inappropriate experience or were poorly briefed. It therefore recommended that additional staff be redeployed from clusters in the regional office to the ISTs, and that NPOs be trained in country offices so that they could become resource persons to support the work of ISTs.

130. The scope of the JIU review did not include the validation of the evaluation findings. However, the Inspectors appreciate this initiative and join the recommendations of the evaluation aimed at enhancing the capacity and delivery of ISTs.

131. In addition to the evaluation findings, **the Inspectors noted that the terms of reference of the ISTs do not include support to intercountry and interregional cooperation among WHO country and regional offices, although such support may de facto occur, and therefore recommend that the objectives, plans and activities of ISTs be revised accordingly.**

The Division of Pacific Technical Support in the WHO Regional Office for the Western Pacific

132. The division was created at the end of 2010 in Suva to pull together the resources for small island countries in remote locations with small populations in one coordination mechanism for the Pacific subregion. A single pool of 19 international staff who were previously scattered among countries and the Regional Office is providing more effective technical expertise tailored to the needs of this group of countries under one CCS. With delegated authority, a decentralized budget and a mobile GSM team, operational and management processes previously handled by the Manila office are being streamlined for speedy support and decision-making. This initiative is still new to assess its performance.

133. Overall, **the Inspectors view these subregional relocated structures and functions at AMRO/PAHO, AFRO and WPRO as positive attempts to bring assistance closer to countries and promote synergies among countries and with partners within the region. They therefore encourage Regional Directors to continue providing an enabling environment in support of them.**

VI. COOPERATION WITH OTHER UNITED NATIONS SYSTEM ORGANIZATIONS

134. The WHO Constitution,[43] the GPW, the MTSP and the biennial programme budget set out the general framework for the establishment of relationships and collaboration between WHO and other United Nations organizations.

135. Formal relations with the United Nations system and other intergovernmental organizations are governed by a series of agreements with the United Nations, its funds, programmes and specialized agencies. In practice, such collaboration is accomplished through participation in intergovernmental processes and health-related events, and in inter-agency coordination mechanisms at the global, regional and country levels. Results are measured in terms of the number of Member States in which WHO is aligning its CCS strategy with the United Nations and other development partners' relevant frameworks, such as the UNDAF, poverty reduction strategy papers and sector-wide approaches.

136. Within the United Nations family the most dynamic WHO partners are the World Bank, UNICEF, the United Nations Population Fund (UNFPA) and the Joint United Nations Programme on HIV/AIDS (UNAIDS), as well as the Food and Agriculture Organization of the United Nations (FAO), Office for the Coordination of Humanitarian Affairs (OCHA), UNDP and the United Nations Environment Programme (UNEP).

137. Three of the eight Millennium Development Goals are health related, and WHO plays a leading role in any related action or event. Currently, WHO, together with UNICEF, is leading the United Nations global consultation on health with Member States, non-governmental organizations, private sector partners and academic and research institutions on the global development agenda beyond 2015, launched by the United Nations Secretary-General, which will culminate in a high-level meeting in February 2013. WHO is working in partnership and alliance with other health-related United Nations organizations in initiatives such as Health 4+ (H4+) to reduce maternal and newborn mortality, and the International Health Partnership (IHP+), to improve health and development outcomes in developing countries. **In this regard, the Inspectors are of the view that there should be congruence between the Millennium development goals, the priorities set in WHO planning documents, the funding provided by WHO donors and actually allocated to them, and the partnerships entered into with United Nations and non-United Nations partners, at all levels of the Organization. This requires a coherent corporate cooperation strategy and structures dedicated to it within WHO.**

138. Also at global level, WHO participates in inter-agency coordination mechanisms, including the United Nations System Chief Executives Board for Coordination and its three pillars, the Executive Committee on Humanitarian Affairs and the Inter-Agency Standing Committee, leading the Global Health Cluster.

139. At regional level, two major work streams have been identified: the participation in United Nations coordination mechanisms, such as the Regional Directors Teams and the Regional Commission Meetings, and the promotion and strengthening of United Nations joint health cooperation initiatives with the ministries of health of the region. These initiatives are regionally born, devised and driven with limited corporate strategic guidance.

140. Coordinating with regional United Nations partners has been challenging, since the design of WHO regions does not coincide with those of other United Nations organizations.

[43] See articles 50 (d) and 69.

To address this constraint, AFRO, for instance, has decided to deploy a team in Dakar where most United Nations partners are located, and has created a post in Addis Ababa to represent the African Union and the Economic Commission for Africa, and to fund a position to liaise with the WHO liaison office in Brussels. The ISTs have also been effective in strengthening partnerships with various United Nations agencies, regional economic communities and other partners.[44]

141. At country level, the WHO participation in the United Nations Country Team (UNCT) and the Delivering as One process has become more and more active. Achieving better alignment of health priorities to national development strategies while negotiating competing priorities among United Nations partners has also been challenging. Leading the health UNDAF process and the humanitarian assistance cluster, accessing funds from multi-donor trust funds and joint programmes, and attending the high number of coordination meetings require capacity, expertise and financing that HWCOs do not necessarily have. The low delegation of authority compared to other United Nations partners to sign and assign resources at country level for joint programming is considered by the HWCOs and UNCT representatives interviewed as a handicap for effective WHO participation.

142. **The Inspectors draw attention to the fact that cooperation at country level is likely to become stronger in the coming years as a result of various United Nations development initiatives. Health-related issues are increasingly becoming important elements of the countries development strategies and UNCT cooperation. To participate effectively in multi-sectoral health programmes and activities at country level, WHO country offices should be provided with improved guidance, tools and possibilities and HWCOs empowered to be operative and capable partners.** Otherwise, other players in the health arena may better respond to these demands and the WHO leadership role in health may be at risk.

143. An Organization-wide strategic approach is needed to address these challenges, remodel the present system of managing United Nations cooperation issues, and reposition WHO as an important partner in development. **To this end, the Inspectors recommend the elaboration of such a strategic approach and that a better flow of information is ensured among responsible office at headquarters, WHO Liaison Offices, regions and countries.**

144. Finally, among existing governing body reporting requirements, the World Health Assembly considers annually a report entitled "Collaboration within the United Nations system and with other intergovernmental organizations",[45] and similar reports are addressed to Regional Committees in SEARO and EURO. These reports are rather descriptive in terms of results achieved and entail no decisions/action. **The Inspectors suggest that such annual reporting be discontinued and replaced by more substantive strategic reports every two years on the challenges faced and resolved and lessons learned by WHO in its cooperation with other United Nations system organizations.**

[44] WHO AFRO IST Evaluation.
[45] See A63/47; A64/42 and A65/39.

Annex

Overview of actions to be taken on the recommendations of the Joint Inspection Unit

	Intended impact	United Nations, its funds and programmes											Specialized agencies, IAEA and ITC																
		United Nations*	UNCTAD*	UNODC	UNEP	UN-Habitat	UNHCR	UNRWA	UNDP	UNFPA	UNICEF	WFP	FAO	IAEA	ICAO	ILO	IMO	ITC	ITU	UNAIDS	UNESCO	UNIDO	UNWTO	UPU	WIPO	WHO	WMO
For action		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☐
For information		☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☐	☒
Recommendation 1	**e**																									**L**	
Recommendation 2	**c**																									**E**	
Recommendation 3	**e**																									**E**	
Recommendation 4	**e**																									**E**	
Recommendation 5	**e**																									**E**	
Recommendation 6	**c**																									**E**	

Legend: **L:** Recommendation for decision by legislative organ
E: Recommendation for action by executive head
Recommendation does not require action by this organization

Intended impact: **a:** enhanced accountability **b:** dissemination of best practices **c:** enhanced coordination and cooperation **d:** enhanced controls and compliance **e:** enhanced effectiveness **f:** significant financial savings **g:** enhanced efficiency **o:** other

* Covers all entities listed in ST/SGB/2002/11 other than UNCTAD, UNODC, UNEP, UN-Habitat, UNHCR, UNRWA.