World Health Organization

**Draft 25 October 2019**

# Thirteenth General Programme of Work, 2019–2023

# WHO Results framework

1. In resolution WHA72.1, the Seventy-second World Health Assembly in May 2019 approved the Programme budget 2020–2021 and requested the Director-General, inter alia, to finalize the measurement system of the results framework of the Thirteenth General Programme of Work, 2019–2023 (GPW13) in consultation with Member States, including through the regional committees, and to present it to the Executive Board at its 146th session in January 2020.

2. The GPW13 focuses on the measurable impact on people's health at the country level. In order to implement this measurement system, a results framework is required to regularly track the joint efforts of the Secretariat, Member States and partners to meet the GPW13 targets and achieve the Sustainable Development Goals, as well as measure the Secretariat's contribution. Additionally, the 2017–2018 assessment of WHO by the Multilateral Organisation Performance Assessment Network stated, in keeping with the increased impact- and outcome-focused approach of the GPW13, that an accurate and reasonable measurement of WHO's contribution is needed and that there needs to be clarity on what is being tracked and measured.[1]

3. The results framework (Annex 1) is accompanied by a system to measure impact - the GPW13 WHO impact measurement[2], the scorecard for output measurement, and qualitative case studies. Together, they provide a holistic view of WHO's overall impact. The GPW13 WHO impact measurement (Annex 2) consists of the top-level indicator of healthy life expectancy (HALE), the triple billion targets and the corresponding indices (Annex 3), and 46 outcome indicators.

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

5. Pursuant to resolution WHA72.1, this document summarizes the plans for: elaboration of the methods for calculating the outcome indicators, each of the triple billion indices and HALE to be subsequently published as a methods report; and finalization of the scorecard. The updated process has incorporated Member States' feedback through the six regional committee meetings. In addition, a

[1] Multilateral Organisation Performance Assessment Network (MOPAN). MOPAN 2017-18 assessments: World Health Organization (WHO). April 2019 (http://www.mopanonline.org/assessments/who2017-18/, accessed 24 June 2019).

[2] Document A72/5.

technical consultation that included experts from Member States and academia has provided inputs to refine the methods for impact measurement.

*Outcome indicators*

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

7. Annex 4 provides a full list of the proposed 46 outcome indicators, 39 of which are SDG indicators. The seven non-SDG indicators, which were approved in World Health Assembly resolutions and have been selected for GPW13, cover antimicrobial resistance (AMR) (antibiotic consumption); polio; risk factors for noncommunicable diseases (obesity; blood pressure; trans-fats); and emergency-related factors (vaccination for emergencies, essential health services for vulnerable populations).

*Universal health coverage index*

8. A combined measure of health service coverage and related financial hardship will be used to monitor progress towards the GPW13 milestones. Health service coverage will continue to be measured using the service coverage index that has been approved by the Inter-agency and Expert Group on SDG indicators (IAEG-SDGs). The methodology to create the index, related to indicator 3.8.1 of the SDGs, is well documented and involves a simple aggregation method.[1]

9. Financial hardship due to large spending on health occurs when a household has to pay a very large share of its disposable income on health services (catastrophic payments) or when payment for health services pushes the household below the poverty line (impoverishing payments). The methodology to estimate financial hardship related to indicator 3.8.2 of the SDGs is also approved by the IAEG-SDGs and documented.[2]

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

*Health emergencies protection index*

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

*Healthier population index*

[1] See the metadata repository of the United Nations Statistics Division (https://unstats.un.org/sdgs/metadata/files/Metadata-03-08-01.pdf, accessed 24 June 2019).

[2] See the metadata repository of the United Nations Statistics Division (https://unstats.un.org/sdgs/metadata/files/Metadata-03-08-02.pdf, accessed 24 June 2019).

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

*Healthy life expectancy*

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

*Methods*

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

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

16. The method for the calculation of the healthier population 1 billion target was developed by a working group in the Secretariat to discuss and address methodological issues. The proposed methodology was reviewed in a consultation with representatives from Member States and experts in October 2019.

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

*Secretariat's accountability*

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

19. The new approach to output measurement adopts a scorecard approach (Annex 5). The new approach is an important step forward to strengthen how performance is measured in WHO. The aim is to introduce an output assessment system which is:

- More meaningful, by relating it more directly to strategic priorities and the work that the secretariat is actually doing.

- More accountable, by providing clear linkages to what is expected under each output and from each budget centre.
- More holistic, by covering different aspects of performance rather the current unidimensional approach using multiple indicators.

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

21. The first three dimensions assess the strategic shifts intended in GPW13 which defines WHO's effective delivery. These are: a) how well the Secretariat has performed its leadership function at all levels; b) the extent to which the Secretariat has delivered the priority global goods critical to achieving the output; and c) the extent to which the Secretariat has delivered technical support to achieve impacts in countries;

22. The assessment of the additional dimensions demonstrates WHO's commitment to mainstreaming of interventions to achieve the output have integrated gender, equity and human rights and to deliver interventions that deliver value for money.

23. The sixth dimension, i.e., achieving results in ways leading to impacts ensures a proper tracking of the influence of WHO's work to the achievement of the outcomes and impacts in countries. By tracking these early indications of success (leading indicators), the Secretariat will be able to demonstrate accountability not only to delivery of outputs but also a contribution to the outcomes and impacts which matter most.

*The elements of the Output Scorecard*:

24. The Output Scorecard approach structures the assessment of performance holistically, using 3 steps:

- Performance is defined and structured around 6 key dimensions of performance that reflect what is strategically important for WHO.
- Performance is assessed for each dimension with a set of performance attributes which set clear expectations of delivery by the Secretariat (e.g., Is the Secretariat providing strategic and authoritative advice on health matters; is the Secretariat delivering the global public health goods which are critical to delivering the outputs). These attributes lay out in clear terms what are being measured under each dimension.
- Each attribute is scored using a 4-point scale, using a common set of criteria across the outputs. A scale with detailed explanation of the differentiation of the ratings is provided for more objective measurement of the attribute. The average score of the attributes under each dimension defines the score for the dimension.

25. The draft Output Scorecard, with the full set of dimensions, is captured in Annex 5.

26. The performance assessment is mainly done through self-assessment with strong internal validation mechanism to be established. There are two exceptions to this. The timely delivery and quality of the Global Public Health Goods will be measured through an independent mechanism (e.g., Science Division) and the results dimension will be measured using a set of leading indicators, which are selected based on a theory of change for each output.

*Consultations and finalization of the Output Scorecard*

27. The Output Scorecard methodology represents an important change in WHO. It requires understanding and the buy-in of staff who will apply the Output Scorecard

28. The work following the presentation of the concept of the Output Scorecard to the WHO centered around testing the idea and developing the measurement instrument to make sure it is robust and credible yet simple enough so it can be put to practice immediately for the 2020-2021 biennium.

29. Several internal consultations with staff across the three levels of the Organization were conducted and the staff input from all three levels of the Organization shaped the measurement instrument in a way that is relevant to measuring their work.

30. The draft measurement instrument in the Annex already represents a refinement based on the consultations and initial pilot testing with Headquarters, regional offices and country offices. Further pilot testing is underway which could potentially lead to further refinements to the measurement instrument, i.e., attributes, criteria, scale and indicators.

*Reporting results*

31. The reporting of results by the Organization will also significantly change to strengthen its accountability for results.

32. The change will start from the process of monitoring, generating data and information from across the Organization. The objective is to strengthen the linkages between CO, RO, and HQ so that the information generated from monitoring not only feeds to reporting globally but also to ensure learning and feeding back to implementation and ensuring focus towards delivery of the outcomes and the triple billion targets across the Organization.

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

34. The reporting will also change. It will harmonize the fragmented pieces in the past, i.e., WHO Statistics, WHO Observatory Reports, programme review reports, country reports and the corporate results reporting. The aim is to strengthen coherence of the reports by using the same data and same source and aligning with the new measurement system for GPW13.

35. The results report to Member States will be done annually. This will be based on the GPW13 results framework which will progressively include all aspect including a reporting on the Output Scorecard, outcomes and triple billion targets. The results report for the biennium 2020-2021 will contain a Scorecard for each of the outputs, and performance of output delivery at each of the levels of the Organization. It will include both quantitative reports on the indicators and indices and the qualitative reports to explain progress, risks, challenges lessons learnt. It will also include case studies which illustrate the impacts influence by WHO's work in countries and also with respect to its normative functions.

36. At the end of the GPW13 period, the Secretariat will present a comprehensive report summarizing progress made towards the GPW13 2023 targets, the triple billion targets and the Secretariat's contribution measured through the Output Scorecard and the qualitative case studies over the 2019–2023 period.

37. Selective country case studies will show-case Organization' impact through sharing experiences on successes and lessons learned, including failure, for becoming a learning organization. These may include case studies from country, regional or global level, but clear country results will be demonstrated, as well as the impact in the lives of people.

*Next steps*

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

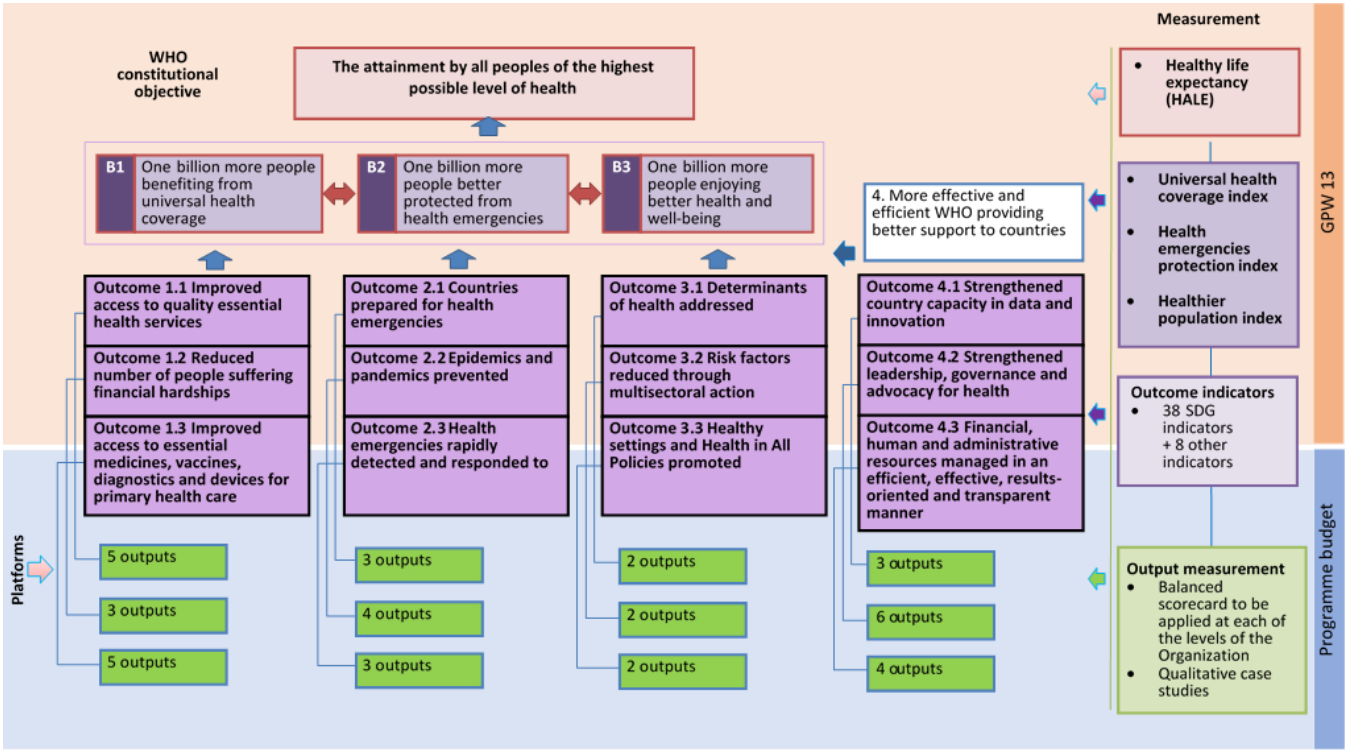
39. The Secretariat will work with all its offices to refine further the output Scorecard measurement instrument to ensure a balance between robustness and credibility versus feasibility of application and simplicity. Member States will be consulted before its finalization and presentation to the World Health Assembly.

**ACTION BY THE EXECUTIVE BOARD**

40. The Executive Board is invited to note the report and comment and provide strategic advice to the finalization of the measurement of the results framework. This will inform the text of the document that will be submitted for consideration by the World Health Assembly at its 73rd session.

## Annex 1

## Thirteenth General Programme of Work, 2019–2023
## Results framework




GPW13: Thirteenth General Programme of Work, 2019–2023; SDG: Sustainable Development Goal.

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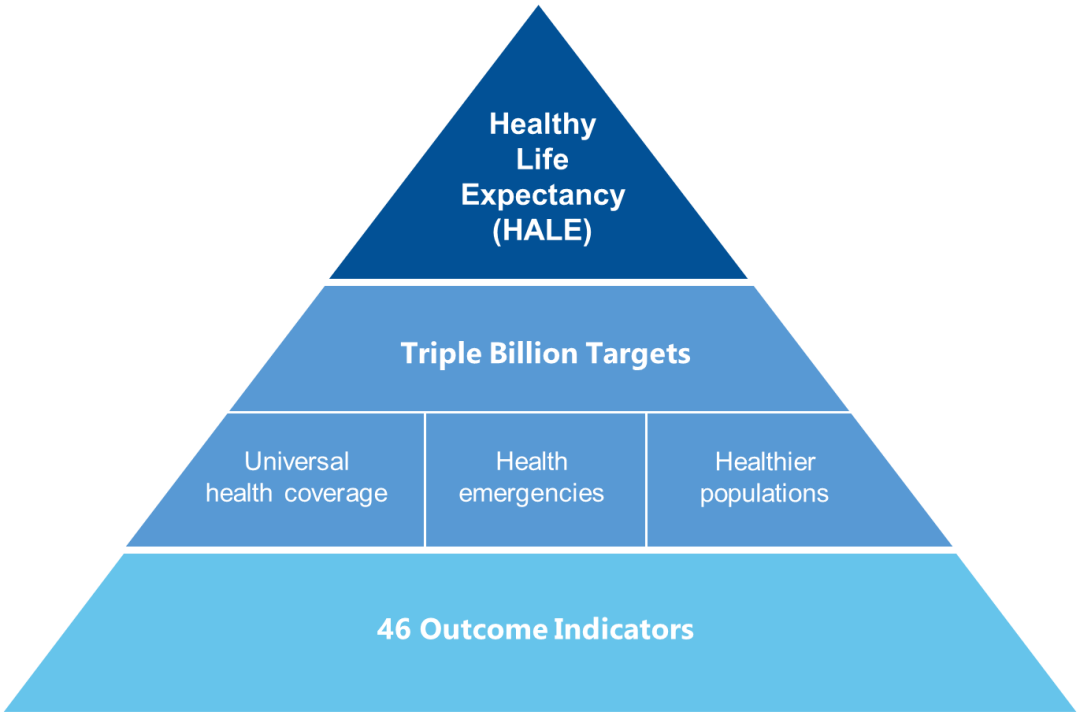
**Annex 2**

**WHO GPW13 Impact Measurement**

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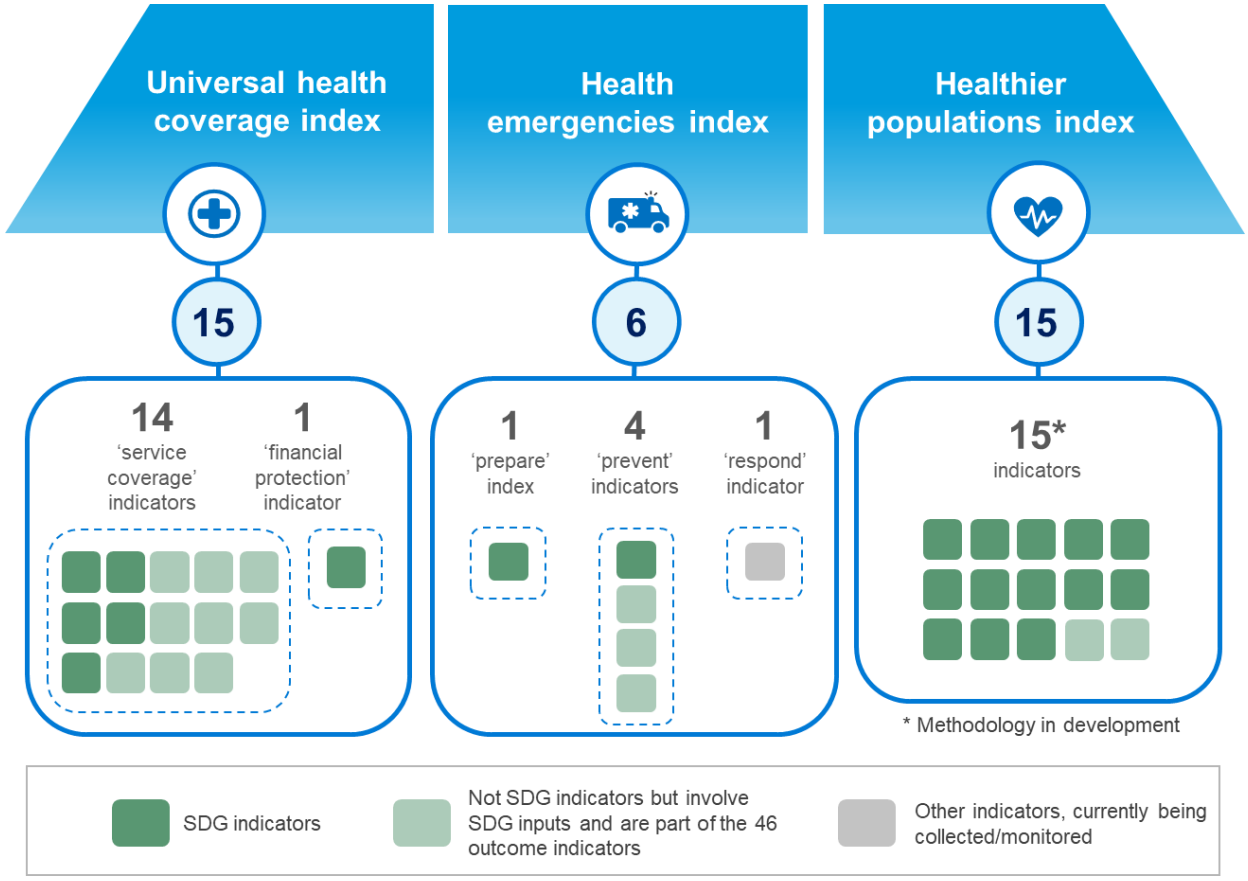
## Annex 3

### Triple Billion Targets and related indices: mapping with SDG indicators



## Annex 4

## Mapping GPW13 outcome indicators to SDG indicators

| SDG / WHA indicator # | Indicator | 2023 Target |
|---|---|---|
| SDG 1.5.1 | Number of deaths, missing persons and directly affected persons attributed to disasters per 100 000 population | Reduce the number of deaths, missing persons and directly affected persons attributed to disasters per 100 000 population |
| SDG 1.a.2 | Proportion of total government spending on essential services (education, health and social protection) | Increase the share of public spending on health by 10% |
| SDG 2.2.1 | Prevalence of stunting (height for age <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age | Reduce the number of stunted children under 5 years of age by 30% |
| SDG 2.2.2 | Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age (wasting) | Reduce the prevalence of wasting among children under 5 years of age to less than 5% |
| SDG 2.2.2 | Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age (overweight) | Halt and begin to reverse the rise in childhood overweight (0-4 years) |
| SDG 3.1.1 | Maternal mortality ratio | Reduce the global maternal mortality ratio by 30% |
| SDG 3.1.2 | Proportion of births attended by skilled health personnel | |
| SDG 3.2.1 | Under-5 mortality rate | Reduce the preventable deaths of newborns and children under 5 years of age by 17% and 30%, respectively |
| SDG 3.2.2 | Neonatal mortality rate | |
| SDG 3.3.1 | Number of new HIV infections per 1 000 uninfected population, by sex, age, and key populations | Reduce number of new HIV infections per 1 000 uninfected population, by sex, age, and key populations by 73% |
| SDG 3.3.2 | Tuberculosis incidence per 100 000 population | Reduce by 27% the number of new TB cases per 100 000 population |
| SDG 3.3.3 | Malaria incidence per 1 000 population | Reduce malaria case incidence by 50% |
| SDG 3.3.4 | Hepatitis B incidence per 100 000 population | Reduce Hepatitis B incidence to 0.5% for children under 5 years |
| SDG 3.3.5 | Number of people requiring interventions against neglected tropical diseases | Reduction of people requiring interventions by 400 million |
| SDG 3.4.1 | Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease | 20% relative reduction in the premature mortality (age 30-70 years) from NCDs (cardiovascular, cancer, diabetes, or chronic respiratory diseases) through prevention and treatment |

| SDG / WHA indicator # | Indicator | 2023 Target |
|---|---|---|
| SDG 3.4.2 | Suicide mortality rate | Reduce suicide mortality rate by 15% |
| SDG 3.5.1 | Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders | Increase service coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders to xx% * |
| SDG 3.5.2 | Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol | 7% relative reduction in the harmful use of alcohol as appropriate, within the national context |
| SDG 3.6.1 | Death rate due to road traffic injuries | Reduce the number of global deaths and injuries from road traffic accidents by 20% |
| SDG 3.7.1 | Proportion of women of reproductive age (15–49 years) who have their need for family planning satisfied with modern methods | Increase the proportion of women of reproductive age (15–49 years) who have their need for family planning satisfied with modern methods to 66% |
| SDG 3.8.1 | Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population) | Increase coverage of essential health services |
| SDG 3.8.2 | Proportion of population with large household expenditures on health as a share of total household expenditures or income | Stop the rise in percent of people suffering financial hardship (defined as out-of-pocket spending exceeding ability to pay) in accessing health services |
| SDG 3.9.1 | Mortality rate attributed to household and ambient air pollution | Reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination |
| SDG 3.9.2 | Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services) | |
| SDG 3.9.3 | Mortality rate attributed to unintentional poisoning | |
| SDG 7.1.2 | Proportion of population with primary reliance on clean fuels and technology | |
| SDG 11.6.2 | Annual mean levels of fine particulate matter (e.g. PM2.5 and PM10) in cities (population weighted) | |
| SDG 3.a.1 | Age-standardized prevalence of current tobacco use among persons aged 15 years and older | 25% relative reduction in prevalence of current tobacco use in persons 15+ years |
| SDG 3.b.1 | Proportion of the target population covered by all vaccines included in their national programme | Increase coverage of 2nd dose of measles containing vaccine (MCV2) to 85% |
| SDG 3.b.3 | Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis | Increase availability of essential medicines for primary health care, including the ones free of charge to 80% |
| SDG 3.c.1 | Health worker density and distribution | Increase health workforce density with improved distribution |
| SDG 3.d.1 | International Health Regulations (IHR) capacity and health emergency preparedness | Increase in member states International Health Regulations capacities |

| SDG / WHA indicator # | Indicator | 2023 Target |
|---|---|---|
| SDG 3.d.2 | Percentage of bloodstream infections due to antimicrobial resistant organisms | Reduce the percentage of bloodstream infections due to selected antimicrobial resistant organisms by 10% |
| SDG 4.2.1 | Proportion of children under 5 years of age who are developmentally on track in health, learning and psychosocial well-being, by sex | Increase the proportion of children under 5 years of age who are developmentally on track in health, learning and psychosocial well-being to 80% |
| SDG 5.2.1 | Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age | Decrease the proportion of ever-partnered women and girls aged 15-49 years subjected to physical or sexual violence by a current or former intimate partner in the previous 12 months from 20% to 15% |
| SDG 5.6.1 | Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care | Increase the proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care to 68% |
| SDG 6.1.1 | Proportion of population using safely managed drinking water services | Provide access to safely managed drinking water services for 1 billion more people |
| SDG 6.2.1 | Proportion of population using (a) safely managed sanitation services and (b) a hand-washing facility with soap and water | Provide access to safely managed sanitation services for 800 million more people |
| SDG 16.2.1 | Proportion of children aged 1-17 years who experienced any physical punishment and/or psychological aggression by caregivers in the past month | Decrease the number of children subjected to violence in the past 12 months, including physical and psychological violence by care givers in the past month, by 20% |
| Health Emergencies | Vaccine coverage of at-risk groups for epidemic or pandemic prone diseases | Increase immunization coverage for cholera, yellow fever, meningococcal meningitis and pandemic influenza |
| Health Emergencies | Proportion of vulnerable people in fragile settings provided with essential health services | Increase the availability of health facilities providing a minimum services package to people in fragile, conflict, or vulnerable settings to at least 80% |
| WHA68.3 | Number of cases of poliomyelitis caused by wild poliovirus (WPV) | Eradicate poliomyelitis: zero cases of poliomyelitis caused by wild poliovirus and establish a clear timetable for the global withdrawal of oral polio vaccines in order to stop outbreaks caused by vaccine-derived poliovirus |
| WHA68.7 | Patterns of antibiotic consumption at national level | ACCESS group antibiotics at ≥60% of overall antibiotic consumption |
| WHA66.10 | Age-standardized prevalence of raised blood pressure among persons aged 18+ years (defined as systolic blood pressure of >140 mmHg and/or diastolic blood pressure >90 mmHg) and mean systolic blood pressure | 20% relative reduction in the prevalence of raised blood pressure |

| SDG / WHA indicator # | Indicator | 2023 Target |
|---|---|---|
| WHA66.10 | Percentage of people protected by effective regulation on transfats | Eliminate industrially produced trans fats (increase the percentage of people protected by effective regulation) |
| WHA66.10 | Prevalence of obesity | Halt and begin to reverse the rise in obesity |

## Annex 5

## Output Scorecard[i]


[i] WHO has established Output Delivery Teams, Outcome Networks and Strategic Priority Networks to ensure coherence in planning, monitoring and reporting and joint delivery of Secretariat's work in line with the integrated results framework. The aim is to work in a coordinated way to achieve the triple billion targets.