PERFORMANCE ASSESSMENT REPORT

Programme Budget 2006–2007

PBPA/2006-2007

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World Health Organization

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Foreword by the Director-General

Effective performance monitoring and assessment are the foundation for sound planning, decision-making, and management.

WHO is proud of its results-based management framework, of which performance monitoring and assessment are an integral part. Tracking and measuring performance helps all of us ensure that resources coming into the Organization are being used effectively and as planned.

This Programme budget 2006–2007 performance assessment report is a tangible expression of the Secretariat's commitment to management by results, improved transparency, and accountability.

The report provides an analysis of results achieved by the Secretariat, as measured against the expected results for the biennium 2006–2007. It pinpoints areas where results fell short of the agreed targets and thus shapes the managerial response. Of the 201 expected results, 55 per cent have been fully achieved.

The report also provides information on financial implementation. This gives us a unique opportunity to analyse, in tandem, technical and financial implementation by area of work.

Although the report reveals some solid progress, I see room for further improvement in the monitoring and assessment of our performance across the Organization. In particular, some of the indicators that guide the Secretariat when measuring performance and impact can be made more precise. I will therefore be asking Member States for some flexibility in changing certain indicators in the Medium-term strategic plan (2008-2013).

When performance indicators are sharper, more measurable, and more relevant, we can do a better job of making sure that resources are translated into results. As I have stated in the past, what gets measured gets done.

I am asking WHO's managers to study this report and to put the findings of the performance assessment to practical use when adjusting workplans for the biennium 2008–2009 and planning for the next programme budget. The report should also be used as a managerial tool when decisions about resource allocation are made.

All these advantages are moving us in the right direction, towards transparent accountability to Member States and better health results within countries where they count the most.

Dr Margaret Chan
Director-General

I OVERVIEW

The Programme budget 2006–2007: performance assessment has two main purposes: to evaluate the Secretariat's performance in achieving the Organization-wide expected results, for which the Secretariat is fully accountable; and to identify the main accomplishments of Member States and the Secretariat in relation to the WHO objectives.

The performance assessment forms an integral part of WHO's results-based management framework. The biennial monitoring and assessment processes, of which it is a part, also include periodic workplan monitoring, and the mid-term review of progress towards the achievement of expected results. The importance of timely monitoring and evaluation for the assessment of programme budget implementation was noted by the Programme, Budget and Administration Committee of the Executive Board at its seventh meeting.[1]

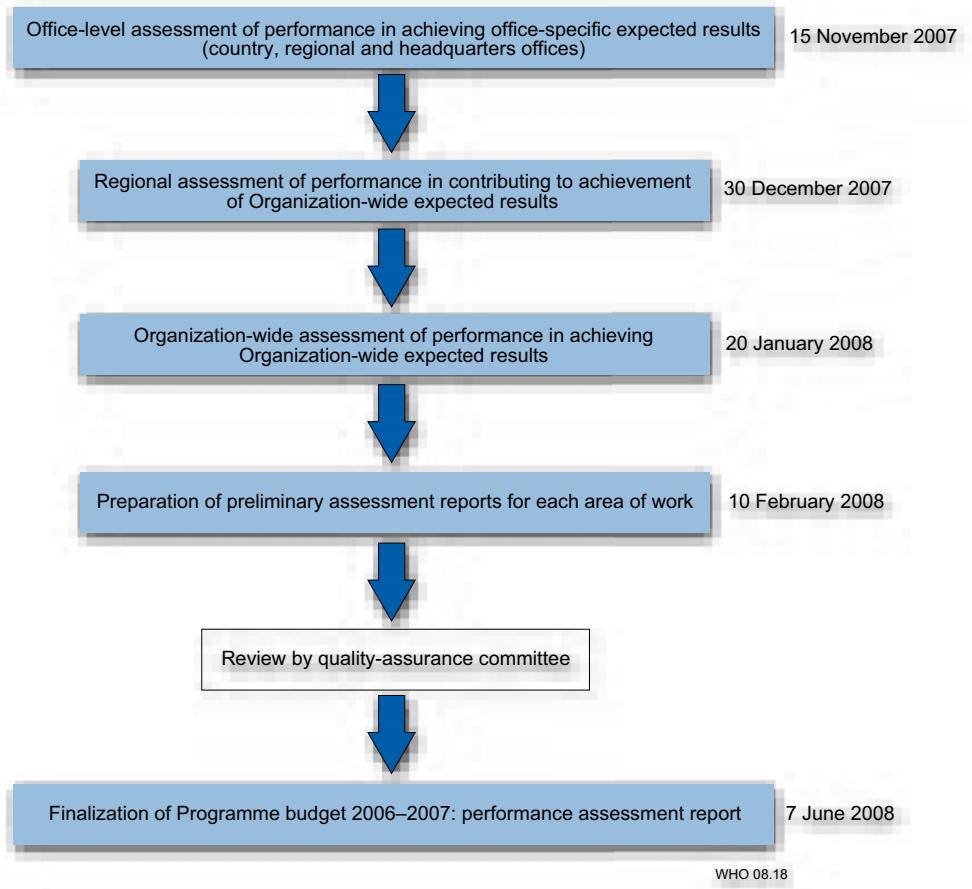
In addition to identifying the main achievements, the performance assessment analyses the following: the success factors, obstacles, lessons learnt and actions required to improve performance, and the financial implementation of the programme budget for each area of work.

The exercise for the biennium 2006–2007 was primarily a self-assessment process, beginning with the evaluation by individual offices (headquarters, and country and regional offices) of their performance in achieving office-specific expected results. Offices reviewed the delivery of products and services, tracked and updated indicator values for the expected results and provided narrative information on the attainment of those results.

The indicator values and comments from office-level performance assessments were consolidated at regional level and synthesized into reports on regional contributions to the achievement of Organization-wide expected results.

[1] Document EB122/3.

Programme budget 2006–2007 performance assessment process



Performance assessment findings from across the Organization were then consolidated at headquarters in order to produce Organization-wide assessment reports for individual areas of work.

In order to improve the reliability and accuracy of the assessment findings a quality-assurance committee, comprising two external experts and one senior WHO staff member, reviewed the reports on all 36 Organization-wide areas of work, identifying inconsistencies, omissions and factual errors. Particular attention was paid to reviewing the evidence for values cited in the reports in respect of the achievement of indicator targets. The reports were then revised in light of the recommendations of the quality-assurance committee. A summary of the recommendations of the quality assurance committee are attached as Annex 2.

The performance assessment is considered to be robust and the most comprehensive evaluation that the Organization undertakes; however, it has some limitations and requires improvement for the future. The introduction of the global management system will greatly facilitate such improvements by providing greater transparency and "real time" data.

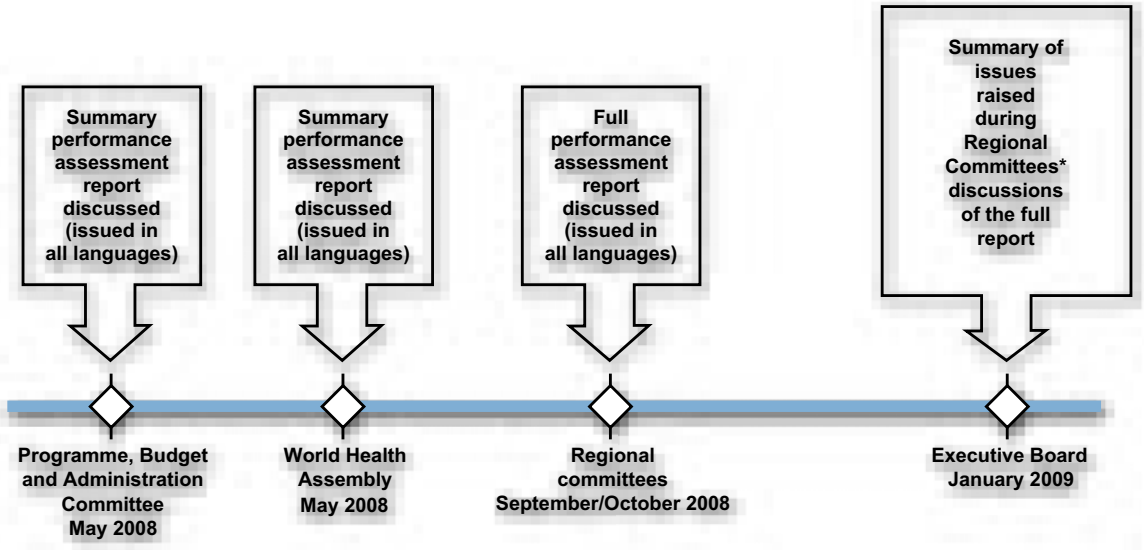
In analysing achievements, particular attention was paid to the indicator target values set in the Programme budget 2006–2007. As indicators do not measure all aspects of an expected result, reliance on indicator values alone in order to determine the extent to which an Organization-wide expected result was achieved can be seen as a methodological limitation. Other weaknesses include the inaccuracy or non-availability of baseline values for some indicators, the existence of

poor-quality indicators that did not lend themselves to measurement, overambitious expected results and indicator targets, and weak indicator tracking by some managers. The definitions and measurability of indicators will be improved.

In addition to providing information to the governing bodies and to managers, the findings of the performance assessment will be used in the preparation of the Proposed programme budget 2010–2011, the reprogramming of operational plans for the biennium 2008–2009 and decision-making for the allocation and re-allocation of human and financial resources.

The Secretariat sees the performance assessment report as a central element of its results-based management framework, and a tangible expression of its adherence to principles of transparency and accountability.

Programme budget performance assessment process: presentation to governing bodies



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In accordance with the schedule illustrated above, which was endorsed by the Programme, Budget and Administration Committee to the Executive Board in January 2007,[2] a summary version of the Programme budget 2006-2007 performance assessment was shared at the Sixty-first World Health Assembly,[3] and the full report will be considered by the regional committees and by the Executive Board at its 124th session in January 2009.

In its report to the Sixty-first World Health Assembly[4] (attached as Annex 1), the Programme, Budget and Administration Committee of the Executive Board commented on the time constraints for preparing both the summary and full performance assessment reports, but stressed the importance of the timely receipt of both. The full assessment findings were needed in order to inform discussions concerning the Programme budget 2010-2011. Some members of the Committee regretted that the established timeline for discussions would deny Member States the opportunity to discuss the full assessment report before the governing bodies' discussion of future proposed programme budgets. It was suggested that the Secretariat submit proposals for rectifying the situation to a subsequent session of the Committee.

[2] Document EB 120/3.
[3] Document A61/19.
[4] Document A61/21.

II ACHIEVEMENT OF WHO OBJECTIVES AND ORGANIZATION-WIDE EXPECTED RESULTS

During the preparation of the Programme budget 2006–2007, the 36 areas of work were divided into four distinct yet interdependent groups of activities: essential health interventions; health policies, systems and products; determinants of health; and effective support for Member States. This report, which is organized according to the same groupings, provides a summary of the main results; it also categorizes performance in relation to the Organization-wide expected results set out in the Programme budget 2006–2007, for whose achievement the Secretariat is held accountable.

The degree of success in achieving the Organization-wide expected results was assessed in line with the following definitions:

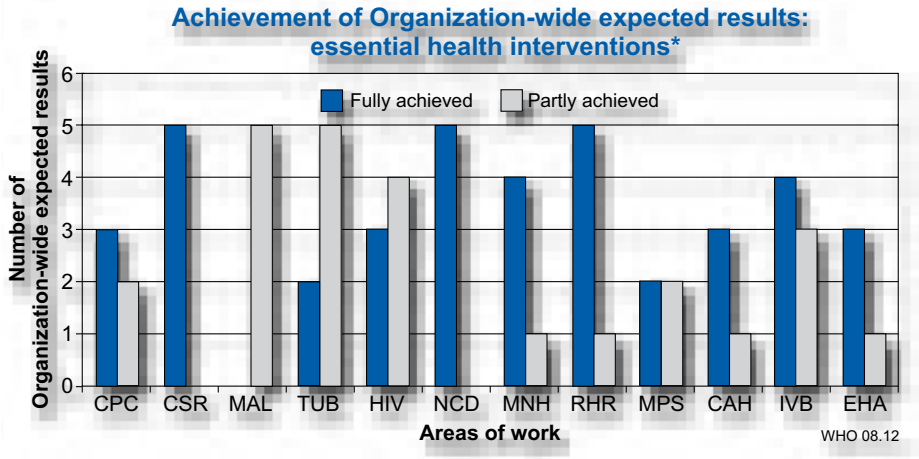
Fully achieved = All indicator targets for the Organization-wide expected result were met or surpassed;

Partly achieved = One or more indicator targets for the Organization-wide expected result were not met;

Abandoned, deferred or insufficient evidence = Changes to original plans resulted in the abandonment of the Organization-wide expected result, achievement of the Organization-wide expected result was deferred to beyond the biennium 2006-2007, or insufficient evidence exists to determine the level of achievement.

Essential health interventions

The Essential health interventions grouping comprises the following areas of work: Communicable disease prevention and control (CPC); Epidemic alert and response (CSR); Malaria (MAL); Tuberculosis (TUB); HIV/AIDS (HIV); Surveillance, prevention and management of chronic, noncommunicable diseases (NCD); Mental health and substance abuse (MNH); Reproductive health (RHR); Making pregnancy safer (MPS); Child and adolescent health (CAH); Immunization and vaccine development (IVB); and Emergency preparedness and response (EHA).



* *In Document A61/19 it is stated that all four organization-wide expected results for the Making pregnancy safer area of work were fully achieved. However, the final assessment is that two organization-wide expected results were fully achieved and two partly achieved.*

Communicable disease prevention and control (CPC)

WHO objective(s)

To reduce morbidity, mortality and disability through the prevention, control and, where appropriate, eradication or elimination of selected endemic tropical diseases using, where possible, a synergetic approach taking into consideration recent Health Assembly resolutions.

Indicator(s) and achievement

- *Number of countries with active national programmes targeting endemic tropical diseases.* With the exception of countries of the European Region not affected by tropical diseases, at least 90 countries in the other five regions reported having an active national programme targeting one or more endemic tropical diseases.
- *Number of countries progressing towards targets set by specific Health Assembly resolutions for the targeted diseases.* More than 75 countries are reported to be making progress towards achieving elimination and/or eradication targets set by specific Health Assembly resolutions.

Main achievements

- In 2006, 49.4 million school-age children in 53 countries and 64.2 million pre-school age children in 35 countries were treated against soil-transmitted helminths.
- In 2006, 63 countries completed mapping of lymphatic filariasis, and in more than 48 countries over 380 million people were treated through mass drug administration.
- In 47 countries, intensified integrated neglected tropical disease control activities have been implemented in a synergetic approach.
- In response to the avian influenza threat, more than 105 countries have updated their national strategic plans for zoonotic diseases, and a total of 20 tools and techniques have been developed and either used or tested for the control of neglected tropical diseases, zoonoses and foodborne diseases.
- Activities have been intensified in the campaign against guinea-worm disease, reducing the number of cases from over 25 200 in 2006 to less than 10 000 at the end of 2007.
- A manual for preventive chemotherapy has been prepared.
- New partnerships have been developed with Sanofi-Aventis, Merck (Germany) and Novartis.
- An independent evaluation of early implementation of neglected tropical disease control in Africa and Asia was conducted in collaboration with the United States Agency for International Development.

Achievement of Organization-wide expected results

Strengthen national capacity to make substantial progress in the intensified control or elimination of targeted endemic tropical diseases

Indicator	Baseline	Target	Achievement
Number of countries that have increased coverage of school-age children with regular treatment against schistosomiasis and soil-transmitted helminth infection to 40% with WHO's support	20	30	53
Number of countries that have completed disease mapping and started mass drug administration to treat lymphatic filariasis with WHO's support	46	55	63
Number of countries that have updated national programmes for the prevention and control of major zoonoses or food-borne disease with WHO's support	50	80	105
Number of countries facing emergencies provided with effective support for applying appropriate prevention and control measures for communicable diseases	8	10	17

Fully achieved. Guidelines and newsletters on controlling the various tropical diseases have been distributed to countries, and training and capacity-building courses have been organized in the African Region. However, a lack of adequate funding is an obstacle to strengthening national capacity for the implementation of tropical disease control and elimination activities. The data on countries that have increased their coverage of school-age children with regular treatment against schistosomiasis and soil-transmitted helminths is based on 53 countries from which it has been possible to acquire formal data. The figure represents fewer than half the 122 endemic countries that should have reported and both the coverage figures and global performance have been affected as a result. At the end of 2006, 24 out of 53 countries reported coverage of over 40% with seven of them achieving above 75%. New funding is now available, through partners, for the integrated implementation of mass drug administration for the elimination of lymphatic filariasis in order to expand the coverage in several countries. Of the 63 countries that have completed disease mapping, 48 have initiated mass drug administration, and in nine, such treatment may not be required. China has successfully eliminated lymphatic filariasis as a public health problem. Schistosomiasis control through integrated mass drug administration is being initiated in countries and promises to be a challenging task for the immediate future. As a result of the human African trypanosomiasis control programme, eight more endemic countries have been screening at least 80% of their at-risk populations in all active foci at least once a year. Four additional human African trypanosomiasis-endemic countries have treated 100% of the cases detected. The Region of the Americas is approaching the regional targets for elimination or control of Chagas disease, lymphatic filariasis, onchocerciasis, soil-transmitted helminthiasis, schistosomiasis, trachoma and leprosy. New techniques and tools for zoonotic, waterborne and foodborne diseases have also been tested and applied in the treatment of fascioliasis and trachoma. Kalazar remains endemic in three Member States in the South-East Asia Region, and a national strategic plan has been implemented in selected districts in Bangladesh. Ongoing efforts in collaboration with FAO and OIE to strengthen activities at the interface between human and animal health for preventing and controlling certain zoonoses and foodborne diseases, in particular avian influenza, have been the driving force behind the updating of national programmes. During the biennium, 55 additional countries updated their national programmes in this regard.

Guidelines, policies and strategies developed for the integrated prevention, control and elimination of endemic tropical diseases, including case management and surveillance

Indicator	Baseline	Target	Achievement
Number of countries implementing synergetic intensified control of endemic tropical diseases with WHO's support	10	20	47
Number of endemic countries receiving support for implementation of integrated vector management	15	30	19
Number of countries receiving support to adapt and implement integrated school-health interventions	80	105	53
Number of countries receiving support to establish effective approaches for the surveillance, prevention and control of emerging enteric diseases	30	80	24

Partly achieved. A new manual for integrated preventive chemotherapy was distributed to countries, as well as other WHO guidelines on various tropical diseases. These documents were used by countries for planning and implementing integrated interventions. At least 47 countries carried out diseases-control activities using a synergetic approach. In the Eastern Mediterranean and Western Pacific Regions, strategic plans for integrated vector management have been developed and will be introduced during the 2008–2009 biennium. The 53 countries reported as having implemented integrated school-health interventions do not include those which might have implemented their activities through ministries of education and, therefore, would not be reported by health ministries. With data for 2007 from the remaining countries and partner organizations yet to be compiled, it is expected that at least 90 countries will have implemented school health interventions. The sustainable financing of activities remains a challenge in most countries as scarce resources tend to be allocated for the control of other communicable diseases, such as HIV/AIDS, tuberculosis and malaria. By the end of 2005, leprosy had been eliminated from the South-East Asia Region. At national level, 11 Member States had succeeded in eliminating the disease by December 2007.

Innovative partnerships developed and maintained to support health ministries for the control of targeted endemic tropical diseases

Indicator	Baseline	Target	Achievement
Number of countries that have built effective partnerships with WHO's support, including with nongovernmental organizations, private providers, civil society or international organizations	80	105	100

Partly achieved. Although regional reports indicate that only 20 countries developed effective partnerships in 2006–2007, in almost all developing countries most health interventions depend on funding through partnerships, grants and agreements involving numerous development funding institutions and organizations, with WHO providing technical and coordinating support. The Global Partners' Meeting on Neglected Tropical Diseases, held at headquarters in April 2007, generated several partnerships, as well as donations, in support of the control of these diseases. A new global partnership on Chagas disease was launched in 2007. Maintaining coordination among the numerous partnerships and health partners at country level is one of the main challenges for both regional offices and headquarters.

Increased access to innovative and cost-effective interventions, techniques and tools

Indicator	Baseline	Target	Achievement
Number of new interventions, techniques and tools developed and tested and/or implemented for endemic tropical diseases, zoonoses and foodborne diseases	Not applicable	2 for zoonoses and food-borne diseases and 2 for endemic tropical diseases	On average, each region had or implemented at least 1 tool or intervention for neglected tropical diseases

Fully achieved. In November 2007, the intradermal application of rabies vaccines for post-exposure treatment in humans was endorsed by the Strategic Advisory Group of Experts. In February 2007, the first field applications of oral rabies vaccine for dogs to prevent and control human and dog rabies was carried out in three Indian States. Preventive chemotherapy interventions, techniques and tools have been developed and/or implemented in countries across all regions. Surveillance and control of Buruli ulcer has been intensified. Tools and methodologies for epidemiological surveillance, such as communication for behavioural impact and geographic information system application for vector control, have been deciding factors in the transmission of some tropical diseases. Several diagnostic tools and new treatments are being developed and tested for human African trypanosomiasis, leishmaniasis and Buruli ulcer.

Innovative and cost-effective interventions, techniques and tools devised and validated for implementation of prevention, control and elimination of communicable diseases in low-resource settings, including in complex emergencies

Indicator	Baseline	Target	Achievement
Number of new integrated case-management strategies for control of neglected communicable diseases	-	5	16
Number of new techniques and tools developed and tested for the surveillance, prevention and control of zoonotic, and water- and food-borne diseases	-	2	2

Fully achieved. The Global Early Warning and Response System for major animal diseases, including zoonoses, continued to be developed and strengthened, particularly on account of its connection with other systems, such as the International Health Regulations (2005) and the International Food Safety Authorities Network (INFOSAN). The network of laboratories for foodborne disease surveillance and antimicrobial resistance in foodborne pathogens continued to expand and to promote advanced laboratory techniques. The testing of "packages" of interventions for multiple zoonoses is planned. In the African Region, three additional countries developed measures for controlling Buruli ulcer. In addition, the eight confirmed endemic countries have strengthened their national programmes. Integrated case-management strategies are also slowly being scaled up in some countries, but inexperience and traditional reliance on more vertical case-management strategies make the acceptance of change a slow process.

Lessons learnt and actions required to improve performance

Lessons learnt

- The level of countries political commitment to the control and elimination of tropical diseases differs between regions. It also determines the resources and funding mobilized for interventions.

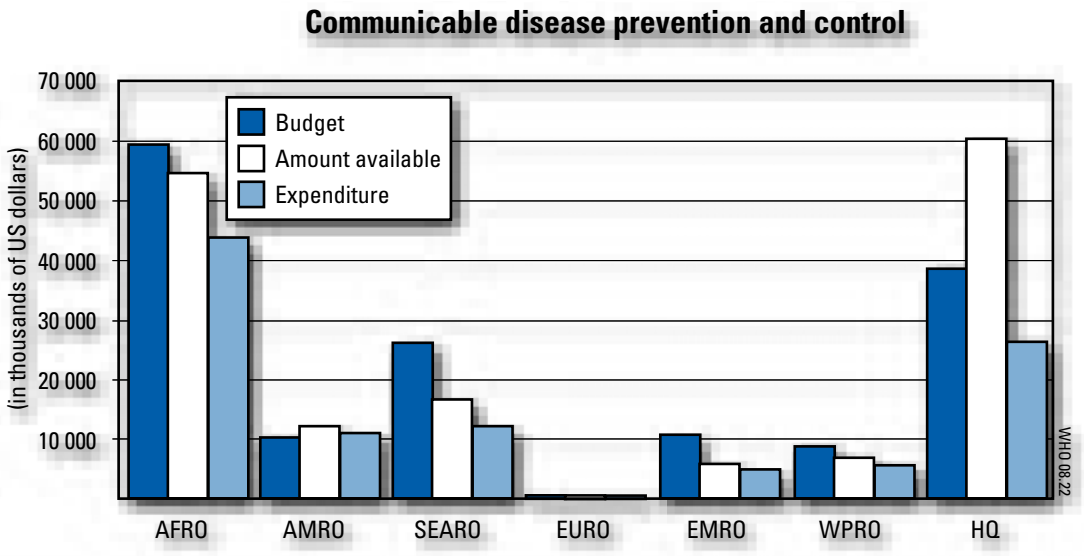
- New initiatives require comprehensive planning and broad consultation, particularly at country level. Integrated and multidisease approaches, as well as the integration of tropical disease control into basic primary health care, are gradually yielding positive results. Although intersectoral approaches are arousing more interest among decision-makers, implementing them remains a challenge.
- Inadequate financial resources and a lack of trained staff continue to impede countries' efforts to implement neglected tropical disease control and elimination activities.
- The training, re-training and recruitment of new human resources continue to constitute a major challenge for most countries in their disease control and elimination efforts.
- Advocacy and social mobilization, as well as local participation, are integral to controlling and eliminating neglected tropical diseases, which primarily affect developing and low-income countries that depend on external funding to implement their health programmes. Securing sustainable funding for implementation is the greatest challenge for countries.
- Data collection is one of the most important elements for improving and measuring achievements.

Required actions

- Additional efforts and resources are needed to secure adoption on a wider scale of integrated multidisease and intersectoral approaches to controlling endemic tropical diseases, and their integration into primary health care systems.
- To develop mechanisms that enhance collaboration between programmes and optimize technical cooperation at national level so that control and elimination activities are coherent, cost effective and efficient.
- To maintain close and coordinated follow-up on the implementation of new strategies at country level.
- Resource mobilization, additional training and professional development are needed to allow the recruitment, training and retention of a strong and reliable workforce that is equal to the task of controlling and eliminating neglected tropical diseases.
- Advocacy and social communication and mobilization must accompany all control and elimination efforts in order to improve the chances of success and sustainability.
- To maintain effective coordination, including interaction across WHO, and to communicate regularly with all partners and stakeholders to ensure their early involvement in planning and organizational processes.

FINANCIAL IMPLEMENTATION

Communicable disease prevention and control												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	3 130	56 049	59 179	3 876	50 767	54 643	92.3%	3 863	39 791	43 654	79.9%	73.8%
AMRO	5 400	4 721	10 121	7 726	4 232	11 958	118.2%	7 649	3 305	10 954	91.6%	108.2%
SEARO	2 212	23 788	26 000	1 890	14 639	16 529	63.6%	1 890	10 106	11 996	72.6%	46.1%
EURO	47	53	100	60	78	138	137.8%	60	78	138	100.0%	138.0%
EMRO	1 722	8 835	10 557	2 150	3 501	5 651	53.5%	2 150	2 688	4 838	85.6%	45.8%
WPRO	1 095	7 405	8 500	1 305	5 394	6 699	78.8%	1 305	4 173	5 478	81.8%	64.4%
Sub-total Regions	**13 606**	**100 851**	**114 457**	**17 006**	**78 613**	**95 619**	**83.5%**	**16 917**	**60 141**	**77 058**	**80.6%**	**67.3%**
HQ	6 453	32 073	38 526	7 408	52 715	60 123	156.1%	7 195	18 919	26 114	43.4%	67.8%
Total	**20 059**	**132 924**	**152 983**	**24 415**	**131 328**	**155 742**	**101.8%**	**24 112**	**79 060**	**103 172**	**66.2%**	**67.4%**



* *Amount available figures are not represented as such in the Financial Report and Audited Financial Statements, but include elements of both income received during 2006-2007 and amounts carried forward from the opening fund balances at 1 January 2006.*

Epidemic alert and response (CSR)

WHO objective(s)

To detect, identify and respond rapidly to threats to national, regional and global health security arising from epidemic-prone, pandemic and emerging infectious diseases of known or unknown etiology, and to integrate these activities with the strengthening of communicable disease surveillance and response systems, national health information systems, and public health programmes and services.

Indicator(s) and achievement

- *Timely detection of and response to epidemics, pandemics and emerging-disease threats of national and international concern*. The demands of avian influenza and preparations for a possible pandemic have generated high levels of activity throughout the Organization. The threat has also led to a more horizontal approach to risk management at headquarters, so that other departments and teams are now collaborating in joint programming and operations for avian and pandemic influenza.

Main achievements

- The first draft of a preparedness plan for human pandemic influenza has been completed. Assessment missions are being carried out to measure levels of preparedness and to assist in building core capacity and strengthening surveillance and response systems.
- WHO's alert and response operations provide a mechanism for responding to epidemics and other public health emergencies on a 24 hours a day, 365 days a year basis and are part of a more comprehensive approach to international health security. The requirements of the International Health Regulations (2005) mean that other programmes, including those dealing with chemical, radiation and food related events need more support. Timely technical assistance was provided through the Global Outbreak Alert and Response Network to countries experiencing major epidemics, including cholera, meningitis, avian influenza, Ebola and Marburg viral hemorrhagic fevers and yellow fever.
- Implementing the International Health Regulations and strengthening international health security will require a scaling up of WHO's early warning and response capacity, as well as the recruitment of long-term human resources in regional and country offices. National focal points have been designated and briefed about their responsibilities, and baseline data collection checklists have been drawn up to assist countries in assessing their public health systems and capacity. The Asia Pacific Strategy for Emerging Diseases has been endorsed by the Regional Committees of both the South-East Asia and Western Pacific Regions. The strategy provides a comprehensive framework to guide the strengthening of national capacity in line with the requirements of the International Health Regulations and should lead to closer cooperation at country and regional level.

Achievement of Organization-wide expected results

Strategy for detecting and responding to epidemics updated and guidance on best ways to provide support to countries drawn up in close collaboration with WHO collaborating centres and international partners

Indicator	Baseline	Target	Achievement
Number of new or updated regional plans of action for implementation of updated strategy	2	6 (1 per region)	6 (1 per region)

Fully achieved. All Member States have received technical support from headquarters and regional offices through subregional or country-specific cooperation strategies to enable them to assess core capacity for surveillance and response and to prepare action plans for addressing identified gaps. Standard operating procedures have been developed or updated for viral haemorrhagic fevers and surveillance enhanced for highly pathogenic avian influenza. Data management tools, including the EPI-Info online health assessment tutorial and user manuals, have been developed and are in circulation. While progress has been made in implementing the Asia Pacific Strategy for Emerging Diseases, weak capacity in public health systems and too few national programmes for emerging infectious diseases are obstacles to achieving regional goals.

Support provided to Member States for strengthening national communicable disease surveillance and response systems, including the capability for early detection, investigation of, and response to, epidemics, pandemics and emerging infectious disease threats

Indicator	Baseline	Target	Achievement
Proportion of low- and middle-income countries supported by WHO that have implemented WHO's recommendations for alert and response to epidemics	40%	60%	60%

Fully achieved. Support has been provided to Member States for strengthening national communicable disease surveillance and response systems. Country assessments have revealed variations in the ability of countries to meet minimum International Health Regulations requirements. It is therefore imperative that testing and validating countries' pandemic influenza preparedness plans continues, including progress made in developing and strengthening capacity for responding to avian influenza outbreaks, preparing for pandemic influenza rapid containment, and improving pandemic response. Human resource constraints in regional and country offices are affecting their ability to assist countries in scaling up their epidemic preparedness, detection and response capacity.

Appropriate alert and response to public health emergencies of international concern coordinated

Indicator	Baseline	Target	Achievement
Proportion of reported outbreaks that were investigated or followed up and verified through collaboration between Member States, the Secretariat, and partners in the Global Outbreak Alert and Response Network	70%	80%	80%
Proportion of requests for WHO's support to which response was provided through the Global Outbreak Alert and Response Network	95%	100%	100%

Fully achieved. Mechanisms for listing and verifying events are now functioning and information is being shared between headquarters and regional offices. WHO, in collaboration with the Global Outbreak Alert and Response Network and other partners, has responded to all requests from Member States for assistance in preparing for and responding to major outbreaks. In general, coordinated alert and response action has proved adequate for dealing with public health emergencies of international concern. However, as avian influenza outbreaks continue, and with the emergence of other infectious diseases in the Western Pacific Region, national action plans are urgently needed to underpin capacity building at country level, particularly in human resources, in order to raise levels of preparedness and improve early detection and rapid response capability.

Effective partnerships formed at regional and global levels to support epidemic alert and response and, in that context, to raise interest and commitment and mobilize adequate resources

Indicator	Baseline	Target	Achievement
Level of financial support for epidemic alert and response mobilized through partnerships at regional and global levels	0	30% increase in financial support	30% increase in financial support
Level of technical partnership in key areas (biosafety, biosecurity, agriculture, communication)	0	10% increase in number of partners in key areas	10% increase in number of partners in key areas

Fully achieved. WHO has participated in regional, subregional and national workshops and meetings to strengthen alliances and increase capacity for responding to pandemic influenza and other major epidemic diseases. In many countries, WHO has played a key role in establishing multisectoral and multi-disciplinary pandemic influenza coordination committees. The Global Alliance for Vaccines and Immunization continues to support a risk assessment and mass vaccination campaign in 12 countries where yellow fever poses a serious threat. Decentralized resource mobilization has enabled regional offices and countries to raise funds for planned activities. The Global Outbreak Alert and Response Network, which now includes 150 partners, continues to play an active role in epidemic response. In addition, WHO, FAO and OIE have formed a partnership and use standard operating procedures for responding to emergencies in the field.

Procedures established for administration of the revised International Health Regulations at national, regional and global levels

Indicator	Baseline	Target	Achievement
Proportion of countries with fully operational focal point for International Health Regulations	0	75%	75%

Fully achieved. WHO is providing technical support, including for sensitizing key stakeholders and for programme coordination, to countries that request assistance in implementing the International Health Regulations. Progress has been made in identifying focal points in Member States and contacts throughout WHO, and working groups have been established to deal with key aspects of implementation. However, it will be necessary to maintain the political momentum, as well as commitment, and to secure appropriate levels of national, bilateral and multilateral investment.

Lessons learnt and actions required to improve performance

Lessons learnt:

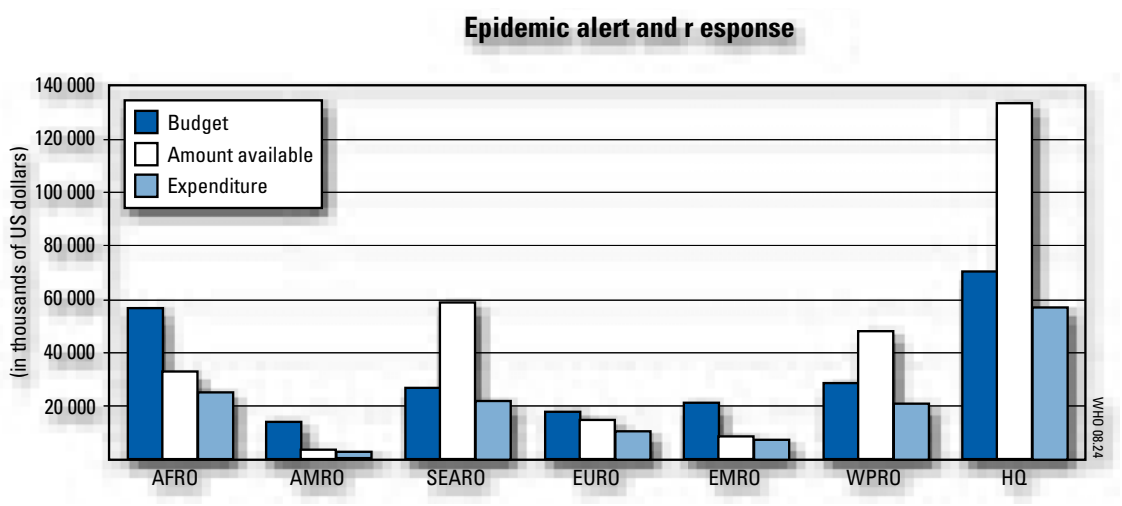
- According to one regional office, the level of resources required to coordinate influenza activities have become increasingly cumbersome because of a lack of leadership in coordinating the channelling of resources mobilized jointly by the leading international technical agencies.
- Government commitment and ownership are crucial for success in building national capacity in surveillance, laboratory confirmation and rapid response to epidemics and outbreaks, including public health emergencies of international concern.
- The level of multisectoral involvement in pandemic preparedness planning varies between countries. Although Member States have developed pandemic preparedness plans, only a few include a rapid containment component.
- Country assessments have revealed variations in the capacity of countries to meet the minimum requirements laid down in the International Health Regulations. Thus, it was not practical to implement a number of planned activities even though the capacity required for doing so was minimal.
- There is a continuing high risk of cross-border transmission and spread of disease on an international scale.
- The Organization's risk management and communications strategies, particularly involving the media, for addressing avian and pandemic influenza have contributed to the mobilization of earmarked resources. A more opportunistic and strategic approach by regional offices would allow the available financial resources to be used more effectively to strengthen capacity for responding to epidemic and pandemic-prone diseases.
- The inability of Member States to fully understand trends in disease occurrence, and to detect at an early stage the emergence and re-emergence of communicable diseases, is mainly due to a shortage of epidemiological and laboratory databases and a failure to maintain and use them correctly.

Required actions:

- To recruit additional human resources.
- Implementation of the International Health Regulations (2005) requires Organization-wide integration of capacity building and hazard management activities encompassing procedures for biological, chemical and radio-nuclear hazards. It also requires finalization, followed by dissemination, of the necessary tools, protocols and guidance in countries and regions.
- The regional strategy for emerging epidemic and pandemic-prone diseases should be finalized. Completion of the development of country profiles and situational analyses of communicable diseases will accelerate the finalization of an evidence-based comprehensive strategy.
- Key national stakeholders should be involved in general pandemic preparedness arrangements. To further strengthen capacity in the prevention of pandemic influenza in countries, national pandemic influenza preparedness plans should be routinely tested and validated.
- For countries to step up their response capability in the event of avian influenza outbreaks, and to prepare for pandemic influenza rapid containment operations, it will be necessary to increase their capacity above the minimum level, albeit gradually.
- To build up regional, subregional and national emergency contingency stocks of medicines, medical supplies and personal protective and logistics equipment, including field communications equipment and transportation for responding rapidly to outbreaks.

Financial implementation

Epidemic alert and response												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	14 617	41 383	56 000	11 001	21 512	32 514	58.1%	10 966	13 910	24 876	76.5%	44.4%
AMRO	2 360	11 108	13 468	2 251	1 358	3 609	26.8%	2 220	924	3 144	87.1%	23.3%
SEARO	4 676	21 324	26 000	5 857	52 807	58 664	225.6%	5 857	15 178	21 035	35.9%	80.9%
EURO	1 483	15 467	16 950	1 617	12 926	14 543	85.8%	1 617	8 557	10 174	70.0%	60.0%
EMRO	3 815	16 711	20 526	2 799	5 477	8 276	40.3%	2 799	3 903	6 702	81.0%	32.7%
WPRO	5 316	22 684	28 000	4 577	43 188	47 765	170.6%	4 577	15 821	20 398	42.7%	72.9%
Sub-total Regions	**32 267**	**128 677**	**160 944**	**28 102**	**137 269**	**165 371**	**102.8%**	**28 036**	**58 293**	**86 329**	**52.2%**	**53.6%**
HQ	15 658	53 917	69 575	13 412	119 568	132 980	191.1%	13 403	43 135	56 538	42.5%	81.3%
Total	**47 925**	**182 594**	**230 519**	**41 514**	**256 838**	**298 351**	**129.4%**	**41 439**	**101 428**	**142 867**	**47.9%**	**62.0%**



* *Amount available figures are not represented as such in the Financial Report and Audited Financial Statements, but include elements of both income received during 2006-2007 and amounts carried forward from the opening fund balances at 1 January 2006.*

MALARIA (MAL)

WHO objective(s)

To facilitate access of populations at risk to effective treatment of malaria; to promote the application of preventive measures against malaria for populations at risk; to build capacity for malaria control; to strengthen malaria-surveillance systems, and the monitoring and evaluation of control.

Indicator(s) and achievement

- *Death rates due to malaria among target groups*. Death rates in the Region of the Americas and the Eastern Mediterranean and Western Pacific Regions, as well as in some countries in the African Region, have fallen significantly. Mortality in the European Region has always been fairly low. It is estimated that there are at least one million deaths each year from malaria, with 82% occurring among children under five years of age. Final results will be published in the World Malaria Report 2008.
- *Incidence of severe and uncomplicated cases of malaria among target groups*. Preliminary results show that incidence of severe and uncomplicated cases of malaria is falling in all regions. In 2007, the number of malaria episodes was estimated at more than 500 million cases per year. Final results will be available in the forthcoming World Malaria Report, 2008.
- *Proportion of households having at least one insecticide-treated bednet*. Preliminary results show that the proportion of households with at least one insecticide-treated bednet is increasing globally, particularly in the African Region. However the proportion is still extremely low in most countries. Preliminary estimates for countries reporting indicated that the proportion of households with at least one insecticide-treated bednet ranged from 6% to 23% in 2007. Final results will be available in the forthcoming World Malaria Report, 2008.
- *Percentage of patients with uncomplicated malaria receiving correct treatment within 24 hours of onset of symptoms*. Preliminary estimates for countries reporting a percentage of children receiving any anti-malarial medicine ranged from 3% to 62% in 2006. Final results will be available in the forthcoming World Malaria Report, 2008.

Main achievements

- Technical support, ranging from capacity building through data analysis to the development of second-generation strategic plans for universal access to proven malaria control interventions, was provided to over 60 countries, 18 of them in the African Region.
- By 1 January 2008, 74 countries, 41 of them in sub-Saharan Africa, had adopted artemisinin-based combination therapies as their national treatment of choice. In the African Region, 25 countries are providing effective treatment with recommended artemisinin-based combination therapies, with 20 reporting country-wide coverage.
- The integrated distribution of insecticide-treated bednets has also been successful where it has been carried out, but the practice needs to be more widely implemented. The "catch-up" strategy of ensuring high coverage with nets, followed by routine distribution for maintenance "keep-up", appears to be the most effective way of increasing coverage. During the biennium, WHO focused on the importance of universal access to insecticide-treated bednets to ensure effective coverage of all at-risk populations.
- Technical cooperation with countries in intensifying malaria surveillance has been continued in all regions with malaria-endemic countries. It has proved particularly helpful in areas with weaker health systems and for monitoring malaria outbreaks and emergencies, especially in the Region of the Americas and the Eastern Mediterranean Region.

- Improvement in morbidity and mortality patterns as a result of large-scale implementation of proven interventions has been recorded in many countries in all regions, notably in Eritrea, Kenya, Rwanda, Sao Tome and Principe, South Africa and Swaziland, and the island of Zanzibar in the African Region. These integrated approaches, sustained by surveillance and expansion of performance-based monitoring, have led to a 69% reduction in malaria mortality in the Region of the Americas, certification of the United Arab Emirates as being free of malaria in the Eastern Mediterranean Region, endorsement of a "malaria elimination" strategy in the European Region, strengthening of country-level surveillance in the South-East Asia Region, and continuing downward trends in malaria morbidity and mortality in the Western Pacific Region.

Achievement of Organization-wide expected results

Access of populations at risk to effective treatment of malaria promoted and facilitated through guidance on treatment policy and implementation

Indicator	Baseline	Target	Achievement
Number of malaria-endemic countries implementing policies on artemisinin-based combination therapy for falciparum malaria	40	50	57
Number of malaria-endemic countries implementing home-treatment programmes for uncomplicated malaria	18	35	25

Partly achieved. By the end of 2007, 74 countries, 41 of them in sub-Saharan Africa, had adopted artemisinin-based combination therapies as their national treatment of choice. In the African Region, 25 countries are providing effective treatment with recommended artemisinin-based combination therapies, with 20 reporting country-wide coverage. The home-based management of malaria strategy is based on: clinical diagnosis of fever in children under 5 years of age; medication with the national first-line medicine, including artemisinin-based combination therapies, for uncomplicated malaria; and rectal artemisinins as pre-referral treatment for severe malaria. The availability of funds has enabled countries to implement new treatment policies. Major constraints to scaling up are inadequacies in forecasting, procurement and supply-chain management. In addition, early indications of artemisinin resistance and poor monitoring of drug efficacy, particularly in the Greater Mekong Subregion, are giving cause for alarm. Weak adherence by many countries to national treatment guidelines, particularly in the private sector, is also an impediment to ensuring effective expansion of treatment using artemisinin-based combination therapies. Extending health-service coverage to areas not within easy reach of health facilities through home-based management of malaria programmes has been hampered by supply-chain problems, which make it difficult to guarantee a supply of first-line and pre-referral treatments. Support activities, such as identifying and training community providers, are also affected.

Application of effective preventive measures against malaria for populations at risk promoted in disease-endemic countries

Indicator	Baseline	Target	Achievement
Number of malaria-endemic countries in which at least 60% of target population have access to insecticide-treated nets	3	40	25
Number of malaria-endemic countries implementing the WHO recommended strategy on malaria in pregnancy	11	35	21
Number of malaria-endemic countries that use weekly malaria-surveillance data in >80% of epidemic-prone districts	5	25	61

Partly achieved. Intermittent preventive treatment is recommended only in areas where transmission is both high and stable, as is the case in Africa. In the African Region, 20 out of 35 countries where intermittent preventive treatment is recommended are implementing it countrywide. Coverage of insecticide-treated bednets is still far below established targets, and many countries are unable to obtain reliable, updated nationwide estimates. Indoor residual spraying was also introduced during the biennium as a crucial pillar of vector control, and it is now in use in all regions, though to differing degrees. In the African Region, seven more countries, namely Angola, Cameroon, Malawi, Nigeria, Senegal, the United Republic of Tanzania and Uganda, have included indoor residual spraying in their national strategies for malaria control, bringing the total number of countries endorsing the method to 25, with 16 spraying routinely. Indoor residual spraying is also being carried out in India. During the 2006 malaria transmission season, more than 5 million structures were sprayed giving protection to more than 20 million people. Increased funding through partnerships and integration with the Expanded Programme on Immunization and antenatal clinic services has contributed to these achievements. Targeted technical assistance from WHO has also been a key factor in ensuring the necessary training and capacity building for integrating net campaigns and effective indoor residual spraying. Combining "catch-up" campaigns and "keep-up" approaches delivered through routine Expanded Programme on Immunization and antenatal clinic services has not proved popular in most countries. There needs to be better communication about the importance of consistency and appropriate use of insecticide-treated bednets in order to change people's behaviour. Weak procurement and supply-chain management, as well as inadequate training and supervision of service providers, also affects intermittent preventive treatment coverage. The difficulty of targeting mobile and remote rural populations has also been an obstacle to ensuring effective coverage. In addition, many countries report a shortage of well-trained staff, particularly entomologists. The reliability of reporting on indoor residual spraying coverage in many countries is also questionable – low quality and mismanagement significantly reduce the effectiveness of this intervention.

Adequate support provided for capacity building in malaria control in countries

Indicator	Baseline	Target	Achievement
Number of malaria-endemic countries where national curriculum for training in malaria control has been updated	2	18	16
Number of malaria-endemic countries using WHO human resource development guidelines to support malaria control	2	18	55

Partly achieved. In most endemic countries health workers are being trained in various aspects of malaria control, using WHO guidelines. In addition, several regions, notably the African, Eastern Mediterranean and South-East Asia Regions, are holding international malaria courses to build local capacity in malaria control. Modules for national malaria courses are being updated through these processes. International training courses for anglophone, francophone and lusophone countries have been organized through collaboration between health ministries, training institutions and partners, including the Bill & Melinda Gates Foundation, the London School of Hygiene and Tropical Medicine and the West African Health Organization. In the Western Pacific Region, a web-based information-sharing tool has also proved effective, while the Eastern Mediterranean Region is carrying out a comprehensive programme for planning and management of malaria with participants from various countries. A number of guidelines, such as the guidelines for the treatment of malaria and on microscopy and elimination have been issued during the biennium. However, additional financial and human resources are needed to update pre-service curricula and courses.

Malaria-surveillance systems and monitoring and evaluation of control programmes functioning at country, regional and global levels

Indicator	Baseline	Target	Achievement
Number of malaria-endemic countries with routine monitoring system for malaria cases and deaths, and reporting annually to WHO	80	90	112
Number of malaria-endemic countries with population-based household surveys conducted for monitoring access to effective treatment within 24 hours	5	40	25
Number of malaria-endemic countries with population-based surveys conducted for monitoring trends in coverage of insecticide-treated nets	57	74	25

Partly achieved. Very few countries have the capacity to collect reliable countrywide information on the coverage of interventions. WHO has made a considerable effort to support countries and regions in collecting data against a targeted set of indicators using the comprehensive malaria database. There has been increased funding for malaria monitoring and evaluation from partnership initiatives. Better survey tools are also now available and there is greater interest and participation in monitoring and evaluation among partners. More consensus-based estimates are being produced and all levels of WHO are focusing attention on improving the quality of data collection, particularly through the global malaria database. The goal of increasing the number of malaria-free areas has also highlighted the importance of surveillance and reporting on malaria indicators. However, weak routine surveillance systems in countries and a shortage of trained staff to report against indicators are limiting progress in this area.

Effective partnerships established and maintained for implementing the global Roll Back Malaria workplan to maximize countries' malaria-control performance

Indicator	Baseline	Target	Achievement
Number of malaria-endemic countries that have functional partnerships for Roll Back Malaria	20	55	78
Number of malaria-endemic countries with a reported increase in financial allocations for malaria-control activities	20	79	77

Partly achieved. The establishment of the Roll Back Malaria Harmonization Working Group in late 2006 has contributed towards the progress made in resource mobilization. In particular, a 75% success rate was achieved by the countries supported by the Working Group. Of 19 Round 7 proposals supported by WHO and its partners in the African Region, 13 (68%) received approval from the Global Fund to Fight AIDS, Tuberculosis and Malaria. Countries also received support from the United States President's Malaria Initiative and the World Bank Booster Program for Malaria Control in Africa. A harmonized workplan was drawn up with Roll Back Malaria partners encompassing programme reviews, needs assessments and provision of intensified implementation support to countries. Collaboration with key partners has enabled countries to gain access to additional funding. Consensus among partners on common goals, as well as on a single harmonized workplan and budget, has also contributed to the progress made. Functioning Roll Back Malaria partnerships have generated wide support as they are seen as a way of harmonizing objectives and assistance to countries.

A key constraint has been limited managerial capacity at country level, so that absorption of available funding is low and no effort is made to solicit additional funding. In addition, cross-border initiatives are not being given enough prominence in efforts to reduce the reintroduction of the parasite into areas where control measures have been effective.

Lessons learnt and actions required to improve performance

Lessons learnt

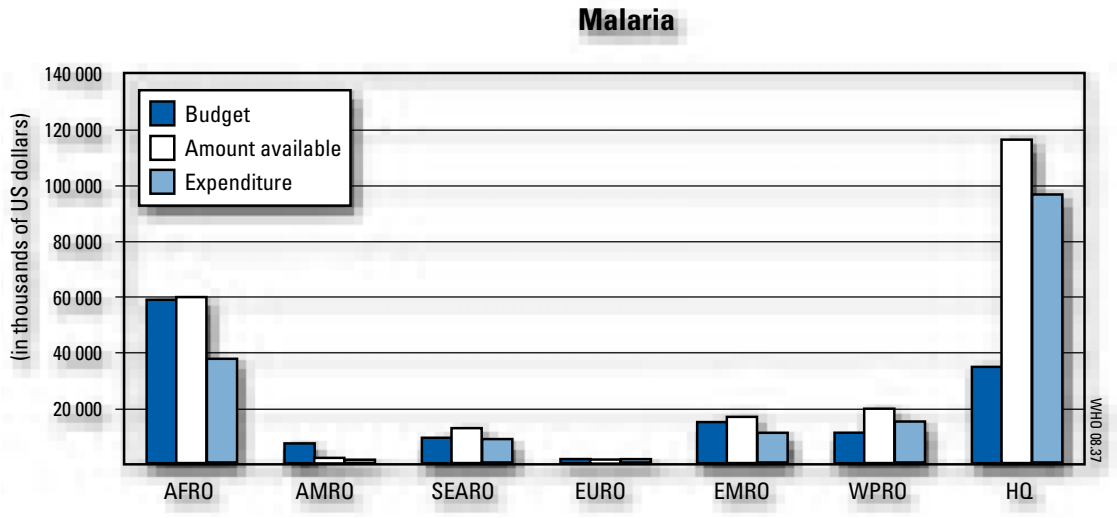
- Malaria control measures, incorporating a comprehensive package of prevention and control interventions combined with full geographical coverage, have quickly led to a decline in morbidity and mortality.
- Advocacy at regional and global level is essential for mobilizing and aligning more partners and resources to accelerate malaria prevention and control efforts.
- WHO's expertise and engagement in supporting the implementation of interventions and in harmonizing partnerships are crucial for success, as evidenced by the Global Fund Round 7 approval rate.
- The strengthening of malaria control systems at country level will be essential for the development, implementation, monitoring and evaluation of plans to provide universal access to malaria control interventions.

Required actions

- To support countries in scaling up malaria prevention and control activities, while ensuring full geographical coverage, in order to have a real impact on people's lives and with the final goal of eliminating the disease.
- A clear allocation of responsibilities among partners is needed to improve cooperation, as well as the quality of the support provided, for a more effective implementation of the required measures.
- To strengthen malaria programmes at both national and subnational levels and to intensify their implementation, as well as co-implementation with other programmes, which should also strengthen the capacity of health systems overall.
- Countries will need support from WHO and other partners for tightening up surveillance and monitoring, as well as evaluation mechanisms in order to acquire more reliable evidence on programme performance and disease trends.

FINANCIAL IMPLEMENTATION

Malaria												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	2 020	56 980	59 000	3 212	56 664	59 876	101.5%	3 179	34 392	37 571	62.7%	63.7%
AMRO	661	6 539	7 200	399	703	1 102	15.3%	388	589	977	88.6%	13.6%
SEARO	2 553	6 881	9 434	2 205	10 682	12 886	136.6%	2 205	6 521	8 726	67.7%	92.5%
EURO	210	1 590	1 800	203	1 229	1 432	79.5%	203	1 137	1 340	93.6%	74.4%
EMRO	1 934	13 066	15 000	1 708	15 106	16 815	112.1%	1 709	9 041	10 750	63.9%	71.7%
WPRO	2 402	8 098	10 500	2 795	16 727	19 522	185.9%	2 794	12 228	15 022	76.9%	143.1%
Sub-total Regions	**9 780**	**93 154**	**102 934**	**10 522**	**101 111**	**111 633**	**108.5%**	**10 478**	**63 908**	**74 386**	**66.6%**	**72.3%**
HQ	5 305	29 270	34 575	5 428	110 828	116 256	336.2%	5 427	90 887	96 314	82.8%	278.6% **
Total	**15 085**	**122 424**	**137 509**	**15 949**	**211 940**	**227 889**	**165.7%**	**15 905**	**154 795**	**170 700**	**74.9%**	**124.1%**



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** *Available resources and expenditure figures for headquarters include supply service trust funds, which are provided by Member States for WHO to carry out procurement on their behalf. These funds are not provided for the implementation of WHO programmes; they are not, therefore, reflected in the Programme budget figures. This explains the variation between budget and expenditure figures in several locations and in particular for headquarters.*

Tuberculosis (TUB)

WHO objective(s)

To expand implementation of the DOTS strategy and strengthen tuberculosis control, by means including strategies and policies on tuberculosis/HIVcoinfection and multidrug-resistant tuberculosis, and of increased involvement of communities, all health-care providers, nongovernmental organizations and corporate partners, through increased country support and by nurturing the Stop TB Partnership; to strengthen surveillance, monitoring and evaluation; and to promote and facilitate research on new diagnostic tools, drugs and vaccines.

Indicator(s) and achievement

DOTS coverage. 90% coverage in 2006.

- *Case-detection and treatment-success rates*. The case-detection rate in 2006 was 61%. The treatment-success rate in 2005 was 85%.
- *Tuberculosis prevalence and mortality rates*. In 2006, the prevalence rate for tuberculosis was 220 per 100 000 population and mortality was 25 per 100 000 population.
- *Level of implementation of new approaches targeting, for example, tuberculosis/HIV coinfection, multidrug-resistant tuberculosis, all health-care providers and communities*. In over 40 countries joint tuberculosis/HIV coinfection interventions are being scaled up. Fifty-one countries are reviewing and supporting multidrug-resistant tuberculosis treatment programmes. Most of the 22 high-tuberculosis-burden countries are pursuing multiple strategies in order to involve a wide range of public and private providers and ensure community participation.
- *Financial resources available for tuberculosis control*. US$ 2 billion were available in 2007.

Main achievements

- The Millennium Development Goal target of halting and beginning to reverse the spread of tuberculosis by 2015 has already been achieved. It is now estimated that tuberculosis incidence rates globally have begun to decline in all regions except the European Region, where the rate is stable. However, as the global population continues to grow, there is a corresponding annual increase in the number of tuberculosis cases. Global tuberculosis prevalence and mortality rates are declining, but not fast enough to be halved by 2015.
- In 2005, the global tuberculosis targets were nearly achieved. In 2006, the treatment-success rate target for 2005 of 85% was almost reached, but there was little progress in case detection: the rate for 2006 of 61% was below the 2005 target of at least 70%.
- The Stop TB Partnership's Global Plan to Stop TB, 2006–2015, which is underpinned by the new Stop TB Strategy, has focused increased global attention on the epidemic and highlighted the financial needs and gaps as identified by WHO. The Global Plan was updated in 2007 in the light of the emergence of extensively drug-resistant tuberculosis. Increased financing has been generated for tuberculosis control in affected countries, but not at the pace required to achieve overall targets, including providing a response to HIV-associated tuberculosis and multidrug-resistant tuberculosis.
- Progress has been made in launching new approaches to expanding access to, and the effectiveness of, tuberculosis control through public–private partnerships, tuberculosis/HIV coinfection collaboration, community engagement and social mobilization, but scaling-up to a degree that will have an impact is now the greatest challenge.

Achievement of Organization-wide expected results

A global plan for DOTS expansion, geared to reaching Millennium Development Goal 6, implemented

Indicator	Baseline	Target	Achievement
Proportion of 22 high-burden countries having long-term plans to achieve Millennium Development Goal 6	5/22	15/22	22/22
Global case detection rates	45%	70%	61%
Global treatment-success rates	82%	85%	85%
Global prevalence rate (per 100 000)	240	≤220	220
Global mortality rate (per 100 000)	27[1]	≤22	25

Partly achieved. All 22 high-burden countries were supported in preparing and updating their national medium-term plans to include the new components of the Stop TB Strategy, which should help them to achieve the 2015 tuberculosis targets. Technical assistance from headquarters and regional and country offices was provided to assist governments in developing and operationalizing these plans. Laboratory capacity remains a major limiting factor for case detection which, coupled with a lack of new diagnostic tools, has prevented any acceleration of tuberculosis case detection. Laboratory capacity, as well as the engagement of all health-care providers in all regions, needs to be scaled up so that more patients can be treated at an earlier stage. The targets for both treatment success and prevalence reduction were met globally. However, treatment success is still substantially below 85% in both the African Region, where HIV/tuberculosis coinfection is mainly responsible for the high mortality, and in the European Region, mainly because of inadequate patient management and high rates of drug resistance. Weak health systems and the difficulty of gaining access to tuberculosis care services are also contributing to low rates of case detection and treatment success and high mortality in some regions.

Implementation of long-term national plans for DOTS expansion and sustained tuberculosis control supported through functional national partnerships

Indicator	Baseline	Target	Achievement
Proportion of the 22 high-burden and other targeted countries with functional national partnerships against tuberculosis	26/87	43/87	More than 30 of 87

Partly achieved. The 87 countries targeted under this indicator include the 22 high-tuberculosis-burden countries, which together carry 80% of the global burden, and some other countries, which for epidemiological and programmatic reasons are regarded as a priority at regional level. Thirteen of the 22 high-tuberculosis-burden countries have national Stop TB partnerships, and most of the others, including the high-priority countries, have functioning bodies for coordinating the scaling-up of tuberculosis control. New national Stop TB partnerships were launched in Ghana and Peru, and technical assistance has been provided for the upcoming launch of four new partnerships. However, significant support is required to help nascent national coordination efforts to become fully functional.

[1] WHO annually reviews and/or updates its tuberculosis epidemiological estimates on the basis of all available data. As a result, the baseline figure for the start of 2006 was revised to 27 from 24.

Global TB Drug Facility and the Green Light Committee maintained and supporting expanded access to treatment and cure

Indicator	Baseline	Target	Achievement
Cumulative number of patients treated with support from the Global TB Drug Facility	6 million	10 million	11 million
Number of countries receiving adequate support from the Green Light Committee	35	50	52

Fully achieved. The milestone of 10 million anti-tuberculosis treatments supplied to 78 countries has now been passed. This was accomplished through the Global TB Drug Facility's grant and direct procurement services within the first six years of operation. The Facility has also begun offering grants for paediatric anti-tuberculosis drugs with support from the International Drug Purchase Facility (UNITAID). Grant agreements have been signed with 43 countries for the supply of approximately 180 000 paediatric treatments. The Facility and UNITAID are also collaborating to address life-threatening shortages of anti-tuberculosis drugs in 19 countries that are scaling up their control efforts. Although future support from either the Global Fund to Fight AIDS, Tuberculosis and Malaria or other donors has been confirmed, coverage is still incomplete. The drug procurement function of the Green Light Committee is carried out by the Global Drug Facility and is being scaled up to allow countries and/or projects to gain quicker access to much-needed second-line drugs. The work is being closely coordinated by the secretariat of the Green Light Committee, which is based in WHO's Stop TB Department and is responsible for reviewing and providing technical assistance for multidrug-resistant tuberculosis programmes.

Political commitment sustained and mobilization of adequate resources ensured through nurturing of the Stop TB Partnership and effective communication of the concept, strategy and progress of the Global Plan to Stop TB

Indicator	Baseline	Target	Achievement
Proportion of targeted countries with internal and/or external financial resources sufficient to close the funding gap	20/45	40/87	24/87

Partly achieved. In resolution WHA 60/19, the Health Assembly committed itself to advancing the objectives of the Global Plan to Stop TB, 2006–2015. The Regional Committee for Africa addressed the tuberculosis emergency in 2006 and the Regional Office for Europe convened a Ministerial Forum on tuberculosis in 2007, at which a Declaration was signed by delegates from 49 countries. The other Regional Committees have also addressed the challenges posed by tuberculosis and the targets to be achieved. High-level missions to high-tuberculosis-burden countries also served to increase awareness of the Global Plan and national commitments. The United Nations Secretary-General's Special Envoy to Stop TB has contributed to all these efforts. Civil-society-led actions to broaden the response to tuberculosis include the Patients' Charter for TB Care. The Stop TB Partnership now encompasses more than 600 partners and a regional partnership has been established in Europe. Despite higher levels of financial provision by affected countries and donor agencies, many countries still lack sufficient funding – particularly for the expansion of tuberculosis/HIV coinfection, multidrug-resistant tuberculosis interventions and case detection – to be in a position to achieve the Global Plan's 2015 targets. WHO has expanded its database and is analysing national tuberculosis-control-financing data more intensively. It is also providing more technical support to Member States to assist them in drawing up their national plans in line with the 2015 targets.

Surveillance and evaluation systems at national, regional and global levels maintained and expanded to monitor progress towards targets, resource allocations for tuberculosis control, and impact of control efforts

Indicator	Baseline	Target	Achievement
Proportion of Member States submitting annual surveillance, monitoring and financial reports for inclusion in the annual global report on tuberculosis control	200/211 for monitoring; 134 for financial reporting	211 for monitoring; 150 for financial reporting	201/212 for monitoring; 156/212 for financial reporting
Proportion of high-burden countries having assessed or measured impact of tuberculosis control on disease burden	5/22	10/22	6/22

Partly achieved. WHO's annual report on Global TB Control provides the indicators used by the United Nations in its reporting on tuberculosis as part of its overall reporting on the Millennium Development Goals. It also provides the indicators used in other global reports, such as the World Bank's World Development Indicators. WHO's analysis of global tuberculosis-control financing is used by the Stop TB Partnership, the Global Fund to Fight AIDS, Tuberculosis and Malaria and other bodies in assessing their contributions to the global response. However, in most regional offices tuberculosis monitoring and evaluation capacity needs to be strengthened. In 2007, a global task force on tuberculosis impact measurement led by WHO set an ambitious agenda for 2008–2009 to encourage partner engagement in order to dramatically increase the number of national tuberculosis prevalence surveys being conducted in high-burden countries and related analyses of the impact of tuberculosis control interventions.

Adequate guidance and support provided to countries to tackle multidrug-resistant tuberculosis and to improve tuberculosis-control strategies in countries with high HIV prevalence

Indicator	Baseline	Target	Achievement
Proportion of countries with heavy multidrug-resistant tuberculosis burdens with Green Light Committee-approved DOTS-Plus programmes	15/62	25/62	52/62
Proportion of countries with data from drug-resistance surveillance	90/211	126/211	118/211
Number of countries with heavy disease burden due to tuberculosis and HIV infection implementing joint activities that involve collaboration between tuberculosis and HIV programmes	15	40	58

Partly achieved. By the end of 2007, treatment of over 30 000 multidrug-resistant tuberculosis patients in 52 countries had been approved by the Green Light Committee. Most of the countries with approved DOTS-Plus programmes are in the Region of the Americas and the European Region. Although the Committee stepped up its efforts during the biennium, and despite continued collaboration with the Global Fund and UNITAID, a rapid rise in the number of countries applying for quality-assured and reduced-price second-line anti-tuberculosis drugs and technical assistance means that fewer than 5% of patients with drug-resistant tuberculosis worldwide are covered by Green Light Committee services. This highlights how urgent the need is for countries to substantially increase the provision of these or equivalent services. Drug resistance data are available from 118 countries worldwide. Thirty-three additional countries have reported on resistance to second-line drugs among multidrug-resistant

tuberculosis cases. Data on the latter in some high-burden countries are still not available, and in the three top-burden countries – China, India and the Russian Federation – information is available only from a small number of provinces, states or oblasts. It is not known whether the prevalence of multidrug-resistant tuberculosis is increasing or decreasing globally, owing to the limited quantity of data on trends in drug resistance obtainable in high-tuberculosis-burden countries compared with high-resource countries. WHO, together with the Centers for Disease Control and Prevention and 25 supranational reference laboratories, has, for the first time, been compiling global data on extensively drug-resistant tuberculosis. It has also overseen the formation of a global extensively drug-resistant tuberculosis task force which is providing initial recommendations for a global response and has guided the preparation of a two-year response plan.

By 2006, according to the latest available data, among the 63 high-priority countries, which collectively account for an estimated 98% of HIV-positive cases worldwide, 58 have established coordinating bodies, prepared joint tuberculosis/HIV coinfection plans and/or undertaken HIV surveillance. Nevertheless, implementation of tuberculosis/HIV coinfection interventions falls short of the targets set out in the Global Plan to Stop TB, 2006–2015, although the evidence from some high-tuberculosis/HIV-burden countries shows that the Global Plan targets are achievable provided committed actions begin immediately.

Better tuberculosis case-detection and cure rates promoted and supported through all public and private providers and community-based services, and integrated respiratory care implemented at primary level

Indicator	Baseline	Target	Achievement
Proportion of targeted countries expanding tuberculosis care through diversified care networks, using public–private entities and community interventions	20/87	40/87	84/87
Proportion of high-burden countries that have implemented strategies to mobilize societies for tuberculosis cure and control	5/22	15/22	22/22
Number of countries with satisfactory tuberculosis-control services implementing integrated respiratory care at primary level	22	32	32

Fully achieved. With support from headquarters and country and regional offices, several countries besides those that were originally targeted, including some high-burden countries, have begun focusing on the new components of the Stop TB Strategy such as public–private partnerships, community interventions, social mobilization and integrated respiratory care through the Practical Approach to Lung Health. In most countries, these interventions are still at an early stage and the extent of the scaling-up process varies considerably. Regional frameworks for public–private partnerships and advocacy, communication and social mobilization have been established in two regional offices. The initiatives for expanding tuberculosis care include public–public and public–private partnerships among institutional providers, community-based networks and individual and group family practitioners. While most countries have launched new initiatives, scaling-up is constrained by a lack of skilled human resources able to provide the necessary training, guidance and monitoring. The strengthening of regional partnerships and advisory groups, as well as collaboration with other health-sector areas, could create the necessary momentum.

Lessons learnt and actions required to improve performance

Lessons learnt

- Continuous efforts are needed to increase political support for tuberculosis control, as well as health systems overall, by generating the necessary resources from national governments and existing and new donors, especially in the face of the threat posed by multidrug-resistant, extensively drug-resistant and HIV-associated tuberculosis.
- Improving basic tuberculosis-control coverage and quality is essential for tackling multidrug-resistant, extensively drug-resistant and HIV-associated tuberculosis.
- There should be a sharper focus on building sustainable national and regional partnerships in order to meet the challenges posed by tuberculosis and described in the other health-related Millennium Development Goals, as well as those facing health systems.
- Enhanced laboratory capacity, infection control, and tuberculosis monitoring and evaluation procedures are urgently needed to improve global and national control efforts and thereby serve patients better.
- The importance of research in the development of new tools for overcoming bottlenecks and reaching more patients, especially the most vulnerable, needs to be intensively promoted.
- Although there is generally better coordination among the wide range of stakeholders involved in tuberculosis control, more countries still need fully operational mechanisms and/or national partnerships in order to be able to implement the Stop TB Strategy and manage wider health-system initiatives more effectively.

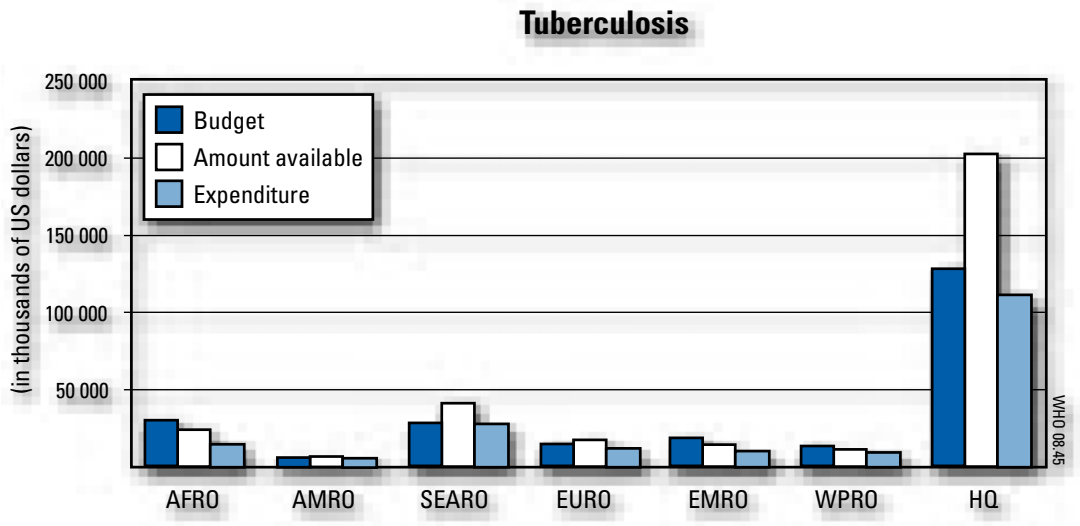
Required actions

- To increase the impact of the Stop TB Partnership's efforts through wider collaboration with civil society, a full range of health providers, public health laboratories, health-system partners, researchers and the corporate sector.
- To further improve coordination of technical assistance in order fully to exploit new resources and help countries and communities manage the array of actions in the Stop TB Strategy.
- To expand the resources available for tuberculosis control and research, and to work closely with new actors in global health in order to access and use new resources efficiently and effectively in the interests of attaining the Millennium Development Goals.

[1] WHO annually reviews and/or updates its tuberculosis epidemiological estimates on the basis of all available data. As a result, the baseline figure for the start of 2006 was revised to 27 from 24.

Financial implementation

Tuberculosis												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	2 371	27 629	30 000	1 617	22 471	24 088	80.3%	1 610	13 288	14 898	61.8%	49.7%
AMRO	559	3 033	3 592	582	3 047	3 629	101.0%	580	2 285	2 865	78.9%	79.8%
SEARO	2 096	25 904	28 000	2 680	37 954	40 634	145.1%	2 680	24 130	26 810	66.0%	95.8%
EURO	1 117	13 383	14 500	761	17 035	17 797	122.7%	761	10 823	11 584	65.1%	79.9%
EMRO	1 625	16 149	17 774	1 192	13 321	14 513	81.7%	1 192	8 822	10 014	69.0%	56.3%
WPRO	1 731	11 269	13 000	1 531	10 409	11 940	91.8%	1 531	7 208	8 739	73.2%	67.2%
Sub-total Regions	**9 499**	**97 367**	**106 866**	**8 364**	**104 238**	**112 601**	**105.4%**	**8 354**	**66 556**	**74 910**	**66.5%**	**70.1%**
HQ	2 337	125 323	127 660	2 246	199 321	201 567	157.9%	2 246	108 371	110 617	54.9%	86.6%
Total	**11 836**	**222 690**	**234 526**	**10 610**	**303 559**	**314 169**	**134.0%**	**10 600**	**174 927**	**185 527**	**59.1%**	**79.1%**



* *Amount available figures are not represented as such in the Financial Report and Audited Financial Statements, but include elements of both income received during 2006-2007 and amounts carried forward from the opening fund balances at 1 January 2006.*

HIV/AIDS (HIV)

WHO objective(s)

To rapidly expand access to treatment and care while accelerating prevention and strengthening health systems to make the health-sector response to HIV/AIDS more effective and comprehensive.

Indicator(s) and achievement

- *Number of developing and middle-income countries providing comprehensive HIV prevention and care programmes*. At least 140 countries are known to be providing a comprehensive prevention and care programme.
- *Percentage of people with advanced HIV infection receiving antiretroviral therapy*. In December 2006, 28% of people living with HIV in low- and middle-income countries were receiving antiretroviral therapy. Antiretroviral treatment coverage data for 2007 will be released in mid-2008.
- *Number of health-care facilities with the capacity and conditions to provide HIV testing and counselling, HIV/AIDS care and antiretroviral treatment*. In September 2007, the African Region reported at least 3000 health facilities providing HIV testing and counselling, care and treatment. The European region reported over 1600 facilities providing antiretroviral treatment in 52 Member States. Data are not available from the other regions.
- *Percentage of health services delivering core prevention package*. It has not been possible to monitor this indicator globally as four regions have been unable to provide figures; the other two have only been able to provide partial information.

Main achievements

- Globally, there has been a reduction in the number of new HIV infections annually and a stabilization of global HIV/AIDS prevalence. The development of new prevention technologies and approaches, such as male circumcision, and the expansion of established prevention strategies, including the prevention of mother-to-child transmission of HIV and harm reduction for drug users, give hope for further HIV/AIDS prevention efforts.
- Increasing numbers of people are accessing HIV testing and counselling services, particularly through the expansion of provider initiated HIV testing and counselling which enable individuals to be referred to appropriate HIV prevention and treatment services.
- The increase in coverage of antiretroviral therapy in all regions during the biennium has contributed significantly to declining HIV-related mortality rates. Whereas there is no evidence that women are disadvantaged in accessing antiretroviral treatment compared with men, equitable access to treatment remains an issue for certain groups, including most-at-risk populations. Prevention and treatment of tuberculosis among people living with HIV/AIDS remains a major challenge, particularly with the emergence of extensively drug resistant tuberculosis and spread of multi-drug resistant tuberculosis.
- HIV/AIDS treatment is becoming more affordable for many as antiretroviral drug prices continue to fall as a result of economies of scale, increased competition be-

tween products prequalified by WHO and price negotiations with pharmaceutical companies. The biggest price reductions have been for first-line antiretroviral drugs.

- The importance of linking HIV/AIDS with a broader strengthening of health systems is being recognized by many countries, donors and other partners. New initiatives to address human resource constraints, health systems financing and the mobilization of additional resources for health service infrastructure are being promoted.
- WHO has contributed towards the overall efforts of the health sector in scaling up programmes to meet the goal of universal access to HIV/AIDS prevention, treatment and care, and has committed itself to producing an annual report on the progress made.

Achievement of Organization-wide expected results

Global and national commitment and available financial resources increased to expand HIV/AIDS treatment and accelerate prevention in countries

Indicator	Baseline	Target	Achievement
Percentage increase in resources channelled to HIV/AIDS	0	20%	Exceeded
Number of countries provided with support by WHO to access funds for HIV/AIDS from the Global Fund to Fight AIDS, Tuberculosis and Malaria and other sources	26	50	77

Fully achieved. The Global Fund to Fight AIDS, Tuberculosis and Malaria has been a key contributor to the increase in financial resources in countries. Headquarters and regional and country offices, with other partners, have supported countries' efforts in both preparing project proposals and implementing projects by providing training for national experts in formulating proposals, assisting in grant negotiations and participating in national coordination mechanisms. However, responding to increasing demand for technical support poses a major challenge for the regional and country offices because of insufficient human resources and a lack of functioning mechanisms. Administrative arrangements between WHO and the Global Fund prevented WHO from being Principal Recipient, however, it was able to assume the role of sub-recipient of grants in a number of countries. Two training sessions on the formulation of Global Fund proposals for Round 7 were attended by representatives from 35 countries. Missions to 16 countries were arranged jointly with UNAIDS to provide support to local employees in the formulation of HIV/AIDS proposals.

PAHO supported countries' efforts in preparing project proposals and in implementing 12 Global Fund projects in the Region, and participated actively in national coordinating mechanisms. In the European Region, partnerships with principal donors were maintained and expanded, notably with the Global Fund. WHO's technical assistance to Member States contributed towards securing funds from donors, including the Global Fund. The Regional Office for the Eastern Mediterranean, in close collaboration with UNAIDS, is supporting the training of national experts in Global Fund proposal development and has assisted 10 countries to formulate proposals and negotiate grants. Demand for technical support in implementing interventions supported by the Global Fund has been steadily increasing, posing a major challenge for the Regional Office's over-stretched human resource base. In the Western Pacific Region, the Global Fund has been the key contributor to the increase in countries' financial resources, which are being used to expand HIV/AIDS treatment and to accelerate prevention. As demand for technical assistance becomes more pressing, WHO's

capacity to respond is constrained by staff shortages. In the South-East Asia Region, assistance from WHO with Global Fund proposal development has helped to increase resources. Among countries that have had their proposals accepted a significantly higher percentage have been supported by WHO.

Countries provided with support to expand treatment and care of HIV/AIDS equitably using a public health approach, and simultaneously to accelerate HIV prevention delivered through the health system

Indicator	Baseline	Target	Achievement
Number of countries achieving national treatment targets for women, men and children receiving treatment according to WHO guidelines	5	20	24 (number of low- and middle-income countries having more than 50% coverage of people needing antiretroviral therapy by end of 2006)
Number of countries delivering core prevention package in 80% of health facilities to contribute to Millennium Development Goal Target 7	0	20	Information unavailable
Number of countries offering basic services for prevention of mother-to-child transmission of HIV to 80% of pregnant women, contributing to Millennium Development Goal Targets 5 and 6	5	20	3 (at least 48 low- and middle-income countries reported offering some prevention of mother-to-child transmission of HIV services to pregnant women, but only 3 countries offered 80% of HIV-infected pregnant women antiretroviral treatment)

Partly achieved. By the end of 2006, 24 low- and middle-income countries had achieved more than 50% coverage of people needing antiretroviral therapy, while 42 low- and middle-income countries were providing treatment to at least 28% of those in need. The 2007 data on antiretroviral therapy will be available by May 2008. In 2006, WHO issued a series of new HIV/AIDS treatment guidelines, including on adults and adolescents, infants and children, prevention of mother-to-child transmission of HIV, and co-trimoxazole prophylaxis. In 2006, although at least 48 low- and middle-income countries reported offering some prevention of mother-to-child transmission of HIV services to pregnant women, only three countries offered 80% of HIV-infected pregnant women antiretroviral treatment. The 2007 data on prevention of mother-to-child-transmission of HIV will be available by May 2008.

The High Level Global Partners' Forum met in Johannesburg in November 2007, to review progress and achievements since the 2005 Abuja Call to Action towards an HIV and AIDS free generation and developed global guidance on prevention of mother-to-child transmission of HIV. In the African Region, updated guidelines on new approaches, including provider initiated testing and counselling, have been made available to countries. Half the countries in the Region were given support to expand HIV/AIDS testing and counselling and prevention of mother-to-child transmission of HIV, resulting in an increase in the percentage of districts with at least one facility providing HIV testing and counselling from 5% in 2004–2005 to 60% in 2006–2007. PAHO supported a review of national plans by ministries of health in 10 priority countries, namely Belize, Bolivia, Colombia, Ecuador, El Salvador, Guatemala, Guyana, Honduras, Nicaragua and Peru, guided by the Regional HIV/STI Plan for the Health Sector 2006–2015. The Regional Office for Europe, focused its work on increasing the number of countries providing antiretroviral treatment and harm reduction interventions for injecting drug users as the main transmission risk group. A series of HIV/AIDS treatment and care protocols for the European Region were also developed. Working in partnership with other organizations, WHO and United Nations agencies within the Three Ones framework, contributed towards the scaling up of interven-

tions, such as those recommended in the United Nations Millennium Development Goals and the Dublin Declaration, as well as by the United Nations General Assembly Special Session on HIV/AIDS. With the exception of Afghanistan and Iraq, all Eastern Mediterranean Region countries are providing HIV/AIDS treatment and care services. Overall coverage of people living with HIV/AIDS in need of antiretroviral treatment is only 6% out of an estimated 79%. The Regional Office supported nine countries in the development of treatment, guidelines, scale-up plans, health worker training and mentoring. The major obstacle to expanding access to treatment is the lack of quality HIV testing and counselling for people who wish to know their HIV status without fear of breaches of confidentiality, stigma and discrimination. In the Western Pacific Region, where HIV prevalence is low, interventions have mainly been centred on most-at-risk populations. Scaling up successful pilot projects in countries has been a challenge, particularly harm reduction programmes for people who inject drugs and the 100% condom use programme for sex workers and their clients. In the South-East Asia Region, progress has been made towards achieving universal access targets through sustained advocacy and implementation support in key areas. Over the last two years, prevention has been strengthened through targeted interventions for highest risk populations and high levels of coverage have been achieved in countries with the most advanced epidemics. As a result, declining trends have been documented in Thailand, Myanmar and the most affected Indian states.

Countries provided with support to strengthen the capacity of their health systems to respond to HIV/AIDS and related conditions, including support for health-sector policy development, planning, integrated training and service delivery with other health services, including maternal and child health, family planning, tuberculosis, sexually transmitted infections and drug dependence-treatment services

Indicator	Baseline	Target	Achievement
Number of countries provided with support by WHO to develop and implement health workforce plans and strategies incorporating HIV/AIDS needs	According to surveys conducted in 2005	Additional 15 countries	27
Number of countries implementing integrated/coordinated policies on tuberculosis/HIV infection	20	30 to 40	49
Number of countries attaining national treatment targets	25	50	Detailed information to be published in a separate report in mid 2008

Fully achieved. To provide guidance on enhancing tuberculosis/HIV collaboration, a regional strategy was developed and adopted by the Regional Committee for Africa at its Fifty-seventh session. In the African region, 23 countries established coordination and capacity building mechanisms in order to implement tuberculosis/HIV co-management more effectively. The number of countries conducting tuberculosis/HIV collaborative activities has increased from 15 in 2005 to 34 in 2007 as a result of the technical support provided. This has led to an increase in the percentage of tuberculosis patients being screened for HIV from an average of 2% to 14%. However, in Rwanda the percentage has increased to 75%. The Regional Office for Europe focused on developing sustainable institutions for workforces specializing in HIV/AIDS prevention, treatment and care, including the expansion of knowledge hubs for pooling capacity and expertise across the Region in order to increase and maintain training programmes in line with WHO technical guidance. The Regional Office for the Eastern Mediterranean supported four countries in the development and implementation of collaborative plans for HIV and tuberculosis programmes and provided training for programme managers in most countries. Six countries have been assisted in carrying out strategic planning for a health-sector response, and a programme re-

view guide and tools have been initiated. In the Western Pacific Region, progress has been made in HIV/AIDS prevention and care, as well as in the development of policies and national strategic plans and in building the capacity of country staff. The Regional Office for South-East Asia contributed to health-sector policy development and planning by providing assistance in strategic planning and in conducting external reviews of national programmes. Although progress has been made in initiating WHO recommended tuberculosis/HIV collaborative activities, a recent survey of WHO HIV country officers in 64 tuberculosis/HIV high-burden countries selected as being representative of all WHO regions, provides an insight into implementation at country level. Although progress is reported in the development of a policy on cotrimoxazole, limited purchase and supply of the medication for this indication, scarce human resources and weak drug supply management systems have hampered national scale-up. Some countries have made progress in implementing tuberculosis/HIV policies, but they remain under-utilized.

Support provided to countries to ensure uninterrupted supply of HIV-related commodities and medicines, including ensuring quality through prequalification of medicines and validation of diagnostics

Indicator	Baseline	Target	Achievement
Number of countries in which key stakeholders in the public and private sectors and nongovernmental organizations, receive biannual update with information on strategic procurement and supply management	40	140	110
Number of heavily burdened countries that receive substantial technical support from WHO or its partners to increase access to affordable essential medicines	20	40	37

Partly achieved. The Global Price Reporting Mechanism summary report on the AIDS Medicines and Diagnostics Service web site was accessed more than 16 000 times in 2007. In 2006–2007, 70 countries received procurement and supply management support through regional and global level workshops and follow-up activities. Thirty of the workshops were supported by the AIDS Medicines and Diagnostics Service. The database on the regulatory status of antiretroviral drugs on the AIDS Medicines and Diagnostics Service web site was accessed more than 7000 times during 2007.

The Regional Office for Africa provided support to countries for key elements of the procurement and supply management cycle in response to countries' requests, and 25 countries have received buffer stocks of HIV/AIDS medicines to prevent unnecessary interruptions in life-saving treatment. The Region of the Americas provided support to several countries through the PAHO Regional Revolving Fund for Strategic Public Health Supplies in order to strengthen procurement and supply management systems, promote an integrated approach to the supply of HIV/AIDS medicines and commodities, monitor pricing, develop efficient and transparent procurement processes based on market knowledge, and foster in-country product supply management. With this fund's assistance, countries purchased US$ 14 million worth of products, of which 82% were for HIV/AIDS. The Regional Office for Europe, through its pharmaceuticals programme, assisted Member States to acquire and maintain an uninterrupted supply of commodities for HIV/AIDS prevention, treatment and care by providing support in the areas of quality control, supply chain management, intellectual property and price reduction. The Regional Office for the Eastern Mediterranean provided technical support to Sudan for strengthening procurement and supplies management, and to Morocco for drawing up price reduction strategies. A region-wide review of antiretroviral prices was carried out and the results presented at the National AIDS Programme Managers meeting in 2007. National programme managers requested the Regional Office to continue antiretroviral price monitoring and to make its findings available to all health ministries.

Involvement of affected communities and other partners in health sector responses to HIV/AIDS increased

Indicator	Baseline	Target	Achievement
Number of partners engaged with WHO for attaining prevention, treatment and care targets	150	200	200
Number of organizations of people living with HIV/AIDS demonstrating greater knowledge about HIV/AIDS and treatment issues and ability to convey that information to their constituents for access to treatment for those who need it, and/or community mobilization through assistance from WHO	60	100	150

Fully achieved. WHO collaborates with partners and people living with HIV/AIDS through letters of agreement and contracting mechanisms. Partnerships have been formed at country and regional level through the International Treatment Preparedness Coalition, the International Community of Women Living with HIV/AIDS and the Global Network of People Living with HIV/AIDS, and work is carried out jointly on issues related to treatment access, treatment literacy, readiness for care and prevention strategies. In the African Region, strong partnerships have been forged with the help of, among others, the United Nations system, the United States President's Emergency Plan for HIV/AIDS Relief, the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Bill and Melinda Gates Foundation. Strategies to accelerate HIV/AIDS prevention have been launched in 46 African countries with support and encouragement from the African Union and the Southern Africa Development Community Secretariat. The Regional Office of the Americas has been seeking to increase political commitment for stepping up the response to HIV/AIDS. All countries in the Region have ratified the universal access agenda, and PAHO has intensified its efforts to widen participation by civil society in regional processes, particularly strategies on people living with HIV/AIDS. Through close working relationships and partnerships with civil society, the Regional Office for Europe has enhanced WHO's advocacy and promoted its approaches and policies while developing normative guidance and policy frameworks. In the South-East Asia Region, participation by affected communities has served to strengthen the overall response to HIV/AIDS, especially in countries with strong national programmes. In countries with weak national programmes, however, involving and coordinating the efforts of nongovernmental organizations without fragmenting the national response remains a challenge. In all regions, partnerships have been used by governments and civil society to enhance the implementation of WHO's policies, programmes and guidelines. These relationships are crucial for maintaining the fabric of society and enhancing the overall effectiveness of health programming in countries.

Normative guidelines and other tools and programme guidance used for HIV/AIDS prevention, treatment and care based on a public health approach and evidence from operational research and targeted evaluation

Indicator	Baseline	Target	Achievement
Number of countries using guidelines on Integrated Management of Adolescent and Adult Illness for HIV/AIDS prevention, treatment and care	20	60	54
Number of countries with WHO-supported operational research programmes	4	10	37

Partly achieved. Support for operational research ranging from funding to direct involvement in protocol design and implementation has been provided by headquarters and five regional offices. In the African Region, 23 countries have implemented the Integrated Management of Adult and Adolescent Illness approach to scale up antiretroviral treatment, and thousands of front-line health workers, including expert patients, are being trained to provide HIV/AIDS care and treatment as a result. An additional six countries have adapted generic materials or introduced the Integrated Management of Adult and Adolescent Illness approach in limited geographic areas. The availability of second generation surveillance guidelines, as well as sufficient capacity to gather and analyse data for surveillance has facilitated the implementation of HIV/AIDS surveillance activities in the majority of countries. As yet, there is not the same level of investment in HIV-related operational research. However, 10 countries have been given support to design and conduct operational research, which may have contributed to a better understanding of the epidemic at country level. In the Regional Office for the Americas, four sets of WHO guidelines have been translated into Spanish and adapted to suit regional needs. The UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases gathered scientific evidence for field-testing rapid syphilis tests in Bolivia, Brazil, Haiti and Peru, and final guidelines have been published to support Member States in eliminating congenital syphilis. The Regional Office for Europe focused on developing and disseminating 13 regional clinical protocols for the treatment and care of people living with HIV/AIDS, and on providing ongoing assistance to countries for the development of normative acts and clinical standards. In the Eastern Mediterranean Region, an adapted Integrated Management of Adult and Adolescent Illness approach was implemented in Somalia, Sudan and Yemen. In the South-East Asia Region specially adapted guidelines and training tools for the Integrated Management of Adult and Adolescent Illness were implemented in India, Indonesia and Myanmar, while India and Thailand received WHO support for operational research programmes. The Regional Office for the Western Pacific developed, adapted and/or revised numerous norms and guidelines for the prevention of HIV/AIDS and sexually transmitted infections and for the treatment and support of those living with them at both regional and country level. Further advocacy with ministries of health is required to ensure that these guidelines are implemented in accordance with countries' needs.

Global, regional and national reporting and surveillance systems strengthened to provide more accurate strategic information on the epidemic and the response to it

Indicator	Baseline	Target	Achievement
Number of countries that regularly collect, analyse and report surveillance, coverage and outcome data, using WHO's standardized methodologies	50	75	88
Number of countries reporting on surveillance and monitoring of HIV/AIDS drug resistance based on WHO guidelines	5	40	23

Partly achieved. Among countries whose surveillance systems were rated according to second generation surveillance principles, 56 were judged to have fully functioning systems, 32 had partially functioning systems, and 47 were rated as having poorly functioning or non-existent sentinel surveillance systems. In the African Region, 36 countries conducted HIV sentinel surveillance work and 12 have conducted national threshold surveys for HIV/AIDS drug resistance. All countries reported that drug resistance rates were less than 5% , that is, of no public health significance. The Regional Office provided technical assistance to countries for training, quality assurance and data analysis. The Regional Office for the Americas initiated a regional HIV/AIDS drug resistance surveillance network. Training workshops were conducted

and a subregional HIV/AIDS drug resistance strategy was developed for the Caribbean and Latin America. The establishment of a system for HIV/AIDS drug resistance surveillance will continue to be a priority. The Regional Office for Europe has paid particular attention to surveillance, monitoring and evaluation of sexually transmitted infections, HIV and viral hepatitis, and to the response to the epidemic. Surveillance was carried out with the European Centre for Disease Prevention and Control using the joint reporting form, and monitoring of treatment and care continued through the annual survey encompassing 53 Member States. In the Eastern Mediterranean Region, three countries have implemented second generation HIV/AIDS surveillance systems; others rely mainly on case reporting. Approximately 80 surveillance personnel attended regional and international training courses at the School of Public Health's Knowledge Hub for Capacity Building in HIV/AIDS Surveillance in Zagreb, with WHO support. Most countries in the Western Pacific Region implemented second generation surveillance, and data management and patient tracking systems are now in place in Cambodia. Key achievements include building staff capacity through regional training and meetings, and provision of technical support to national consensus meetings. In the South-East Asia Region, nine out of 11 countries have implemented some elements of an integrated surveillance system, including surveillance for risk behaviours and sexually transmitted infections, HIV sentinel surveillance and HIV/AIDS case reporting. Support provided by the Regional Office included: direct technical assistance, procurement of HIV/AIDS kits, training, monitoring and quality assurance, data analysis and interpretation of results for guiding national HIV/AIDS prevention programmes.

Lessons learnt and actions required to improve performance

Lessons learnt:

- Strong advocacy, national ownership and leadership are required to generate results.
- Overall strengthening of health systems is needed to reach the universal access goal and sustain what has been achieved.
- Effective targeted interventions, guided by reliable surveillance, are essential for successful prevention.
- Strong national HIV/AIDS programmes with uniform standards in the health sector are essential for a coordinated response. WHO's support for capacity building in national HIV/AIDS programmes is crucial for eliciting both a balanced response and the effective use of available resources.
- The strengthening of health systems requires increased human resource capacity through ongoing planning and recruitment.
- The capacity of many countries for collecting, analysing and using key information on the HIV/AIDS epidemic and the response to it needs to be strengthened.
- The technical indicators of the expected results need to be more specific and measurable, and in many cases the targets were set too low.

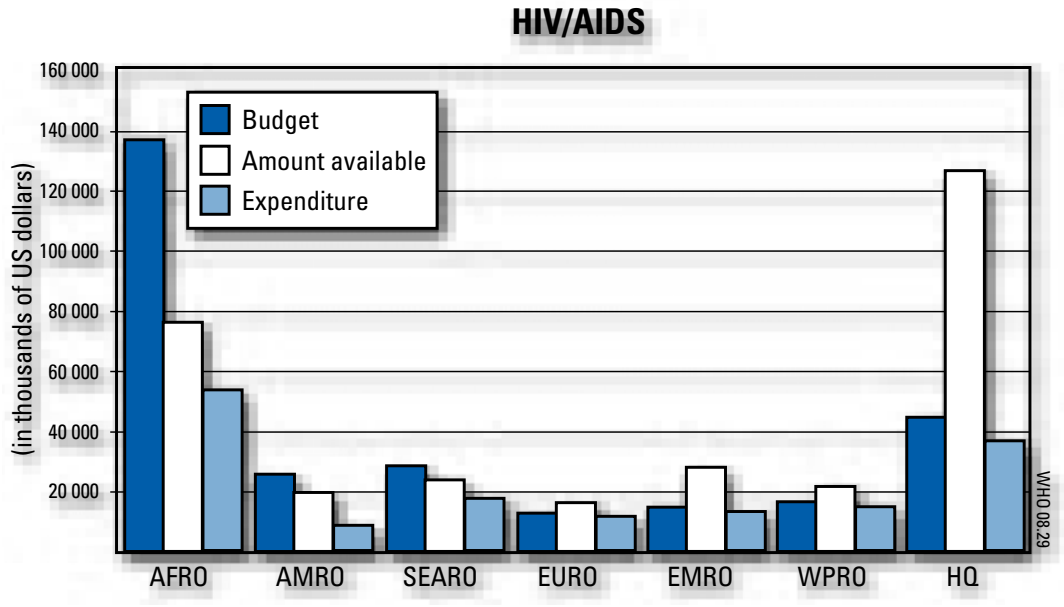
Required actions:

- To advocate for the acceleration of key HIV/AIDS prevention interventions leading towards the goal of universal access, including full integration of a comprehensive prevention of mother-to-child transmission of HIV approach.
- To advocate for the continuance of evidence-based HIV/AIDS prevention, treatment and care in order to achieve the objective of halting and reversing the trend of the epidemic.

- To support countries in strengthening, monitoring and evaluating their systems in order to better document the impact of HIV/AIDS interventions.
- To use HIV/AIDS prevention interventions as entry points for strengthening health systems, particularly human resources, laboratories, procurement and supply management and health information systems, to allow better delivery of services.
- To implement different interventions in an integrated and comprehensive manner to ensure their synergy and alignment.
- To collaborate with countries in improving regional surveillance systems and strengthening country systems.
- To monitor progress towards universal access to HIVAIDS prevention, treatment and care in the health sector using a global framework, which should also be the main mechanism for measuring WHO's own contribution.
- To continue to assist Member States to develop policies and strategies for increasing sustainable funding in order to achieve the goal of universal access to HIV/AIDS prevention, treatment and care.
- To ensure sustained systemic responses to the HIV/AIDS epidemic through multisectoral approaches, partnerships with other stakeholders and good coordination.
- To ensure the availability of reliable data for guiding epidemic surveillance, monitoring and evaluation in a way that is appropriate to countries' needs.

Financial implementation

HIV/AIDS												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	4 662	130 935	135 597	4 796	70 870	75 665	55.8%	4 784	48 591	53 375	70.5%	39.4%
AMRO	956	24 167	25 123	1 000	12 267	13 266	52.8%	982	7 213	8 195	61.8%	32.6%
SEARO	2 373	25 744	28 117	1 993	21 639	23 631	84.1%	1 992	15 243	17 235	72.9%	61.3%
EURO	1 161	10 889	12 050	694	15 104	15 798	131.1%	694	10 607	11 301	71.5%	93.8%
EMRO	1 370	12 689	14 059	806	17 380	27 554	196.0%	807	11 554	12 361	44.9%	87.9%
WPRO	1 123	14 945	16 068	886	20 002	20 888	130.0%	887	13 651	14 538	69.6%	90.5%
Sub-total Regions	**11 645**	**219 369**	**231 014**	**10 175**	**157 261**	**176 804**	**76.5%**	**10 146**	**106 859**	**117 005**	**66.2%**	**50.6%**
HQ	4 503	39 376	43 879	4 328	121 777	126 105	287.4%	4 328	31 835	36 163	28.7%	82.4%
Total	**16 148**	**258 745**	**274 893**	**14 503**	**279 038**	**293 540**	**106.8%**	**14 474**	**138 694**	**153 168**	**52.2%**	**55.7%**



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Surveillance, prevention and management of chronic, noncommunicable diseases (NCD)

WHO objective(s)

To build surveillance systems; to reduce exposure to the major risk factors; and to help health systems respond appropriately to the rising burden of chronic, noncommunicable diseases.

Indicator(s) and achievement

- *Regional burden of chronic, noncommunicable diseases*. The burden of chronic, noncommunicable diseases continues to grow in all regions. According to the latest estimates, chronic, noncommunicable diseases are responsible for 60% of all deaths globally, with 80% of these deaths occurring in low- and middle-income countries. The rapidly increasing incidence in poor and disadvantaged populations is contributing to widening health gaps between and within countries.
- *Disability-adjusted life years related to avoidable blindness and deafness*. For the first time, a reduction in the global burden of blindness and visual impairment was recorded, mainly due to the progress made in implementing specific programmes. However, new data have revealed that 153 million people are estimated to be visually impaired from uncorrected refractive errors. Significant progress has been made in the collection of data documenting deafness and hearing impairment.

Main achievements

- Regional strategies and frameworks have been developed and endorsed in three regions: the European Strategy for the Prevention and Control of Noncommunicable Diseases, an integrated framework for noncommunicable disease surveillance in the South-East Asia Region and an overall framework of action for noncommunicable diseases in the Pacific in the Western Pacific Region.
- The area of prevention and control of noncommunicable diseases has attracted high-level political commitment at regional and subregional level as evidenced by the Caribbean Community Heads of Government Summit, the Seychelles Declaration and the European Ministerial Conference on Counteracting Obesity. Numerous stakeholders have been mobilized through various initiatives, such as the Trans Fat Free Americas Initiative and the European Heart Health Charter.
- Data collection on risk factors through STEPS surveys has progressed in most regions.
- An increasing number of countries have developed national policies, plans and programmes for the prevention and control of noncommunicable diseases. Technical assistance has been provided to Member States to strengthen their capacity to address noncommunicable diseases, especially through the training of programme managers and senior health decision-makers.
- Blindness prevention activities have made advances in all regions, especially through the development of national action plans. Epidemiological assessment of hearing impairment has been carried out in most regions and the size and nature of the problem is now more accurately known.

Achievement of Organization-wide expected results

Support provided to countries for framing policies and strategies for prevention and management of chronic, noncommunicable diseases at national level, including integration of primary and secondary prevention into health systems

Indicator	Baseline	Target	Achievement
Number of targeted countries that have used WHO guidelines for the integration of primary and secondary prevention and management of chronic, noncommunicable diseases into health services	0	20	The dissemination of WHO guidelines was completed as planned. They are being used in most Member States
Availability of analysis of the status of chronic, noncommunicable diseases, and their prevention, management and control	Global report on chronic, noncommunicable diseases (2005)	Follow-up report on chronic, noncommunicable diseases (2006)	Seven additional versions of the report were issued

Fully achieved. A number of guidelines and technical reports have been completed, including: guidelines on the definition of diabetes,[1] a report on the prevention of diabetes and its complications,[2] guiding principles on the management of birth defects and haemoglobin disorders,[3] haemoglobin disorders,[4] addressing congenital malformations,[5] the final report of the WRIGHT project,[6] pocket guidelines with cardiovascular risk-prediction charts for assessment and management of cardiovascular risk,[7] and a report on global surveillance, prevention and control of chronic respiratory diseases.[8] Technical support has continued to be given to Member States for the integrated prevention and management of chronic, noncommunicable diseases. The report on chronic, noncommunicable diseases[9] has been translated into Chinese, French, Italian, Portuguese, Russian and Spanish and was used to increase awareness in regional and national follow-up events in Brazil, Canada, Chile, China, Egypt, Fiji, Finland, Greece, India, Islamic Republic of Iran, Malaysia, Maldives, Nepal, Singapore, Switzerland and Thailand.

Advocacy and provision of support for development of multisectoral strategies and plans to promote action on diet and physical activity in priority countries

Indicator	Baseline	Target	Achievement
Proportion of targeted countries that have adopted multisectoral strategies and plans on diet and physical activity in conformity with WHO's recommendations	0%	10%	Over 25 countries (13%)

Fully achieved. Although implementation of the Global Strategy on Diet, Physical Activity and Health has been slow, primarily owing to resource constraints, some progress has been made in all regions and several Member States' plans have been put into effect. In the African Region, 26% of Member States are implementing the Global Strategy; in the Region of the Americas, 55% have adopted multisectoral strategies; in the European Region, almost all countries have food and/or nutrition policies, at least 26% have plans for physical activity and/or obesity and at least 52% have strategies which include nutrition and/or physical activity; in the South-East Asia Region, national action plans based on the Global Strategy have been formulated in 35% of

1 Definition and diagnosis of diabetes mellitus and intermediate hyperglycemia: report of a World Health Organization/International Diabetes Federation consultation. Geneva, World Health Organization, 2006.
2 Prevention of diabetes mellitus and its complications. Geneva, World Health Organization (in press).
3 Management of birth defects and haemoglobin disorders. Geneva, World Health Organization, 2006, 1–27.
4 Management of haemoglobin disorders. Geneva, World Health Organization (forthcoming), 1–84.
5 Addressing the global challenges on craniofacial anomalies. Geneva, World Health Organization, 2006, 1–131.
6 WHO Research into Global Hazards of Travel (WRIGHT) Project: final report of phase 1. Geneva, World Health Organization, 2007.
7 Prevention of cardiovascular diseases: pocket guidelines for assessment and management of cardiovascular risk. Geneva, World Health Organization, 2007.
8 Global surveillance, prevention and control of chronic respiratory diseases: a comprehensive approach. Geneva, World Health Organization, 2007.
9 Preventing chronic diseases: a vital investment. Geneva, World Health Organization, 2005.

Member States; and practically all countries and territories in the Western Pacific Region have been involved in workshops to advocate for and support implementation of plans based on the Global Strategy.

Support provided for strengthened capacity of targeted countries to eliminate avoidable visual and hearing impairment as a public health problem

Indicator	Baseline	Target	Achievement
Number of countries implementing national plans to eliminate avoidable visual and hearing impairment as a public health problem in accordance with WHO strategy	60	120	154 countries. 89 national VISION 2020 committees have been established and 65 national VISION 2020 plans formulated

Fully achieved. All target countries have integrated eye and ear public health measures in their national health policies, as scheduled. Guidelines on the prevention of hearing impairment at primary health-care level have been issued and strategies for the prevention and management of diabetic retinopathy disseminated. The global burden of disease has been updated using recent data. Capacity building has been supported through global partnerships and alliances, such as VISION 2020: the Right to Sight Initiative, the Alliance for the Global Elimination of Blinding Trachoma by the Year 2020, World Wide Hearing Care for Developing Countries and Lions Club International SightFirst initiatives.

Effective guidance and support provided for implementation of WHO's surveillance framework for chronic, noncommunicable diseases and their risk factors

Indicator	Baseline	Target	Achievement
Number of countries that regularly collect and analyse data on chronic, noncommunicable diseases and their risk factors and make results available to policy-makers according to WHO's recommendations	10	25	22 new countries (32 in total)
Number of low- and middle-income countries out of those with initial surveillance data collections that regularly collect surveillance data on chronic, noncommunicable diseases according to WHO's recommendations	0	5	6 countries undertook a repeat noncommunicable risk factor survey using the STEPwise approach to chronic disease risk factor surveillance

Fully achieved. Twenty-two new countries introduced a first round of noncommunicable disease risk factor surveillance using the STEPwise approach to chronic disease risk factor surveillance. Of these 22 countries, 14 have completed the field work and data management components of a survey, and an additional 8 have begun collecting data and were still carrying out field work at the end of 2007. A further 16 countries have started planning for such a system. During 2006–2007, WHO expanded its technical support for noncommunicable disease risk-factor surveillance into the Region of the Americas, and the first 10 countries involved initiated a survey. Technical support and advice have been provided to countries through a series of technical training sessions: three training workshops on survey implementation planned and hosted by WHO; five training workshops on data management, analysis and reporting; and eight country-level training workshops supported by headquarters and regional focal points. STEPS material has been made available in various United Nations languages and the STEPS Manual has been translated into French and Spanish.

Improved quality, availability, comparability and dissemination of data on chronic, noncommunicable diseases and their major modifiable risk factors

Indicator	Baseline	Target	Achievement
Availability of comparable data on risk factors for chronic, noncommunicable diseases in the report on surveillance of risk factors	No existing comparable data available for Member States in the first report on surveillance of risk factors	Comparable data for all Member States, with projections of future prevalence in the second report on surveillance of risk factors	Comparable data for all Member States with projection of future prevalence exist for tobacco use, obesity and overweight, systolic blood pressure and total cholesterol
Comprehensive availability of specific information on chronic, noncommunicable diseases and their risk factors in WHO global databases	Standardized information on stroke and diabetes available in the WHO global database	Standardized information on stroke and diabetes, cardiovascular diseases, oral health, respiratory diseases, genetic diseases, blindness and deafness available in the WHO global database	Standardized information is available on all the targeted diseases and conditions

Fully achieved. Because of limited resources, information was not available on all noncommunicable diseases. Work has continued on expanding the WHO Global InfoBase, which provides comprehensive information on noncommunicable diseases and their risk factors. It contains more than 500 000 data points from more than 9000 sources. An improved version was launched in June 2007.

Lessons learnt and actions required to improve performance

Lessons learnt

- A lack of awareness of the magnitude of the problem posed by noncommunicable diseases and the existence of solutions limits political support and the appropriate allocation of resources. Even in countries where interest in noncommunicable diseases is growing, resources still tend to be inadequate. Furthermore, a fragmented approach, both at country level and within WHO, increases the difficulty of responding to the problem to an appropriate degree.
- Multisectoral partnerships and collaboration are crucial to the success of noncommunicable disease programmes. However, health managers and partners outside the health sector have only limited capacity when it comes to implementing public health-oriented noncommunicable disease prevention and control programmes. Building national capacity in prevention and control activities, and integrating noncommunicable disease treatment into primary health-care services are lengthy processes. Evaluation and follow-up are also crucial.
- A positive evaluation of the strategy used to tackle noncommunicable diseases in the Western Pacific Region validated the suitability of the approaches followed, namely: development of national plans; establishment of surveillance systems; promotion of healthy lifestyles and supportive environments; and strengthening of preventive clinical services.

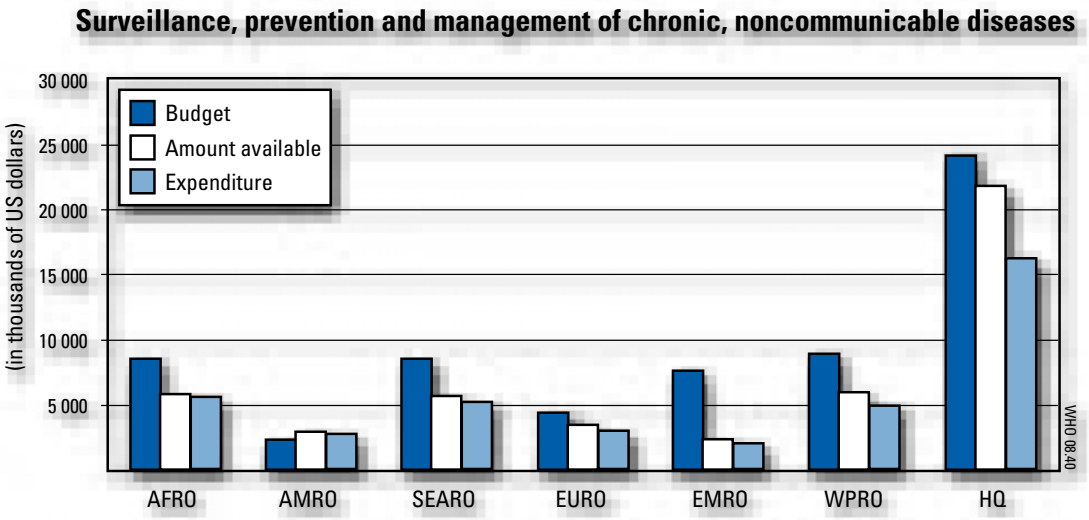
- Using a stepwise approach when working in countries clearly increases the credibility of noncommunicable disease programmes, especially where there is a lack of awareness and resources are very limited. The formulation of national policies, strategies and plans for the integrated prevention and control of noncommunicable diseases is an important entry point for scaling up programmes.
- The creation of national professional officer posts is an effective way of improving coordination and follow-up of noncommunicable disease activities at country level.

Required actions

- To strengthen political commitment to the development of noncommunicable disease programmes, including oral health, blindness and deafness programmes.
- To develop major resource-mobilization initiatives involving governments, the private sector and civil society. These initiatives should include an advocacy and communication campaign in order to reach internal and external audiences at national, subregional and regional levels. They should also take advantage of subregional political integration movements and regional summit processes. The involvement of sectors outside the health sector is crucial if further progress is to be made in the prevention and control of noncommunicable diseases.
- To provide further technical guidance and support for the formulation, implementation, monitoring and evaluation of national noncommunicable disease policies, strategies, and plans, and for setting up programme infrastructures and mobilizing human and financial resources. The recruitment of national professional officers for noncommunicable disease prevention and control in country offices should be regarded as a priority.
- To strengthen technical capacity in regional offices for eye health, hearing loss and other disabilities. Although blindness is not listed in many country cooperation strategy documents, it is recognized as a priority area and should therefore receive more support.
- To develop surveillance and information systems and form links to other information sources, such as the Commission on Social Determinants of Health web site, to reinforce support for advocacy, planning, monitoring and evaluation activities.

FINANCIAL IMPLEMENTATION

Surveillance, prevention and management of chronic, noncommunicable diseases												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	7 641	859	8 500	4 796	1 031	5 827	68.6%	4 763	761	5 524	94.8%	65.0%
AMRO	1 898	463	2 361	2 422	502	2 924	123.8%	2 367	362	2 729	93.3%	115.6%
SEARO	5 204	3 296	8 500	5 007	606	5 614	66.0%	5 008	164	5 172	92.1%	60.8%
EURO	1 792	2 508	4 300	1 991	1 415	3 406	79.2%	1 991	933	2 924	85.8%	68.0%
EMRO	2 715	4 786	7 501	1 337	1 041	2 378	31.7%	1 337	702	2 039	85.7%	27.2%
WPRO	4 611	4 228	8 839	3 884	2 081	5 965	67.5%	3 884	981	4 865	81.6%	55.0%
Sub-total Regions	**23 861**	**16 140**	**40 001**	**19 437**	**6 677**	**26 114**	**65.3%**	**19 350**	**3 903**	**23 253**	**89.1%**	**58.1%**
HQ	6 867	17 235	24 102	6 601	15 188	21 789	90.4%	6 601	9 534	16 135	74.1%	66.9%
Total	**30 728**	**33 375**	**64 103**	**26 038**	**21 865**	**47 903**	**74.7%**	**25 951**	**13 437**	**39 388**	**82.2%**	**61.4%**



* *Amount available figures are not represented as such in the Financial Report and Audited Financial Statements, but include elements of both income received during 2006-2007 and amounts carried forward from the opening fund balances at 1 January 2006.*

Mental health and substance abuse (MNH)

WHO objective(s)

To ensure that mental health and the consequences of substance abuse are taken fully into account in considerations of health and development; to formulate and implement cost-effective responses to the burden of mental and neurological disorders and those related to substance use; and to promote mental health.

Indicator(s) and achievement

- *Proportion of countries that have strengthened policies and services for reducing the burden of mental and neurological disorders and those related to substance use, and for promoting mental health.* A growing number of countries have strengthened their policies and care services for people with mental, neurological and substance-use disorders largely as a result of continuing advocacy by WHO during the two previous bienniums. Progress in low- and middle-income countries has been substantial.
- *Proportion of countries that have taken specific measures to protect the rights of people with mental and neurological disorders and those related to substance use.* Countries are taking specific measures to protect the rights of people with mental, neurological and substance-use disorders, including revising legislation, improving enforcement of human rights measures and training professionals. Specific projects, such as the "chain-free initiative", have helped raise awareness and have triggered innovative activities.
- *Proportion of countries that have implemented evidence-based cost-effective intervention strategies for mental-health promotion, prevention and management of mental and neurological disorders and those related to substance use.* Use of evidence-based intervention strategies for prevention and management of mental, neurological and substance-use disorders has been enhanced. Publications on these disorders, such as Disease Control Priorities Project reports and The Lancet Series on Global Mental Health, produced with the collaboration of WHO, have provided substantial scientific evidence. Other WHO normative and guidance material on specific disorders and conditions has also facilitated this process.

Main achievements

- Concerted efforts by headquarters and regional and country offices have generated vital information and evidence for policies and plans for the prevention and management of mental, neurological and substance-use disorders.
- The quality and amount of technical support provided to Member States have increased substantially with the availability of guidance material on mental, neurological and substance-use disorders.
- WHO has played a leading role in advocating for the protection of the human rights of people with mental, neurological and substance-use disorders.
- WHO is now recognized as a provider of top-quality scientific and research data on public health aspects of mental, neurological and substance-use disorders.
- WHO's efforts have elicited a clear recognition of the need to establish community-based mental health services in low- and middle-income countries.

Achievement of Organization-wide expected results

Support provided to priority countries and countries facing complex emergencies for institutional capacity strengthening in order to develop and implement policies and plans on mental health and substance abuse

Indicator	Baseline	Target	Achievement
Number of countries receiving WHO support that have developed policies and plans for mental health (including alcohol and illicit drugs) with achievable targets	45	69	70
Number of targeted countries that have received WHO support to deal with the mental-health consequences of emergencies	18	30	36

Fully achieved. WHO has provided support to countries in all regions in the form of technical documents, consultations, workshops, strategic document reviews and advocacy at the political level to assist them in drafting policies and plans for the treatment of mental health and substance abuse. Creating and maintaining networks of countries within a region, such as the Pacific Islands Mental Health Network (consisting of 14 countries) and the South-eastern Europe Health Network, has proved to be an effective strategy, which owes much of its success to good collaboration between headquarters and country and regional offices. Substantial progress has also been made in assisting countries to deal with the mental health consequences of emergencies. For example, Sri Lanka has strengthened its mental health policies and services in the aftermath of a major disaster in order to implement much-needed reforms. WHO has worked with other United Nations and humanitarian agencies to develop the Inter-Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings and to provide assistance to countries. A lack of adequate financial and human resources remains an obstacle to providing an immediate response.

Support provided for capacity building in countries in order to develop mental-health legislation, to protect rights of people with mental and neurological disorders and those related to substance use, and to reduce stigmatization and discrimination

Indicator	Baseline	Target	Achievement
Number of countries receiving WHO support that have effectively reviewed or updated mental-health legislation and/or initiated projects to monitor observation of human rights	34	52	55

Fully achieved. WHO's efforts were facilitated by the development of the guidance packages containing modules on mental health legislation and the human rights of people with mental disorders. These normative documents have assisted countries in developing mental health legislation and establishing other mechanisms for protecting the human rights of people with mental, neurological and substance-use disorders. Training was also provided to mental health professionals to improve their knowledge and enable them to furnish advice to countries on drawing up or revising their legislation. The launch of the "chain-free initiative" in the Eastern Mediterranean Region has also focused attention on human rights aspects. The delays that tend to occur at ministerial level are reflected in the time taken to enact national legislation.

Services, research capacity and information systems on mental health and substance abuse within Member States strengthened and supported

Indicator	Baseline	Target	Achievement
Number of countries in which performance of mental-health systems and services has been monitored within WHO's framework of reference	22	39	54
Number of global databases revised and updated on the basis of inputs from countries with gender-disaggregated data	4	9	9

Fully achieved. The capacity of Member States in research and assessment of services has increased. Greater use of the WHO Assessment Instrument for Mental Health Systems (WHO-AIMS) in all regions has ensured that data are available to, and comparable between, countries. Close collaboration between headquarters and country and regional offices has enabled this instrument to be widely used and has also resulted in the revision and updating of global databases so that they are now providing the most accurate global information on mental, neurological and substance-use disorders. Two new publications: *Atlas: nurses in mental health*[1] and *Atlas: global resources for persons with intellectual disability*[2] use data generated by these databases. The Global Alcohol Database has been updated and is available on the WHO web site.

Support provided to improve countries' capability to develop evidence-based strategies, programmes and interventions for prevention and management of mental and neurological disorders, including suicidal behaviours

Indicator	Baseline	Target	Achievement
Percentage of people with epilepsy in selected countries that are untreated	80%	60%	Could not be ascertained
Number of countries receiving WHO support that have developed effective gender-specific interventions for prevention of suicidal behaviours and/or management of mental and neurological disorders	27	51	65

Partly achieved. No reliable information on the percentage of people with epilepsy who are untreated in selected countries could be collected because of a shortage of robust scientific methods to assess the treatment gap. However, progress was made in supporting Member States in planning evidence-based strategies, programmes and interventions to prevent suicide and for the early identification and treatment of epilepsy, mental disorders and substance-use disorders. Strengthening of the Global Campaign Against Epilepsy and Suicide Prevention partnerships has improved performance in these areas. The publication of The Lancet Series on Global Mental Health has generated further scientific evidence of which Member States can make use.

[1] Atlas: nurses in mental health. Geneva, World Health Organization, 2007.
[2] Atlas: global resources for persons with intellectual disability. Geneva, World Health Organization, 2007.

Guidance and support provided to countries for development of evidence-based strategies, programmes and interventions for prevention and management of disorders related to substance use and reducing the adverse health and social consequences of use of alcohol and other psychoactive substances

Indicator	Baseline	Target	Achievement
Number of countries receiving WHO support that have trained staff and developed appropriate programmes for prevention and management of disorders related to substance use and integrated them within primary health care	18	31	40
Number of countries receiving WHO support that have improved the coverage and quality of drug-dependence treatment directed towards HIV prevention and care for injecting drug users	6	21	21

Fully achieved. WHO has been able to respond in a consistent manner to an increasing number of requests from countries relating to the prevention and management of problems and disorders associated with substance use. A number of new normative documents and packages have made this task easier. Inclusion of opioid agonists in the WHO list of essential medicines has also enabled Member States to expand services for people with substance dependence. The existence of a WHO global strategy on alcohol would assist them in devising national strategies to prevent the adverse health and social consequences of alcohol use.

Lessons learnt and actions required to improve performance

Lessons learnt

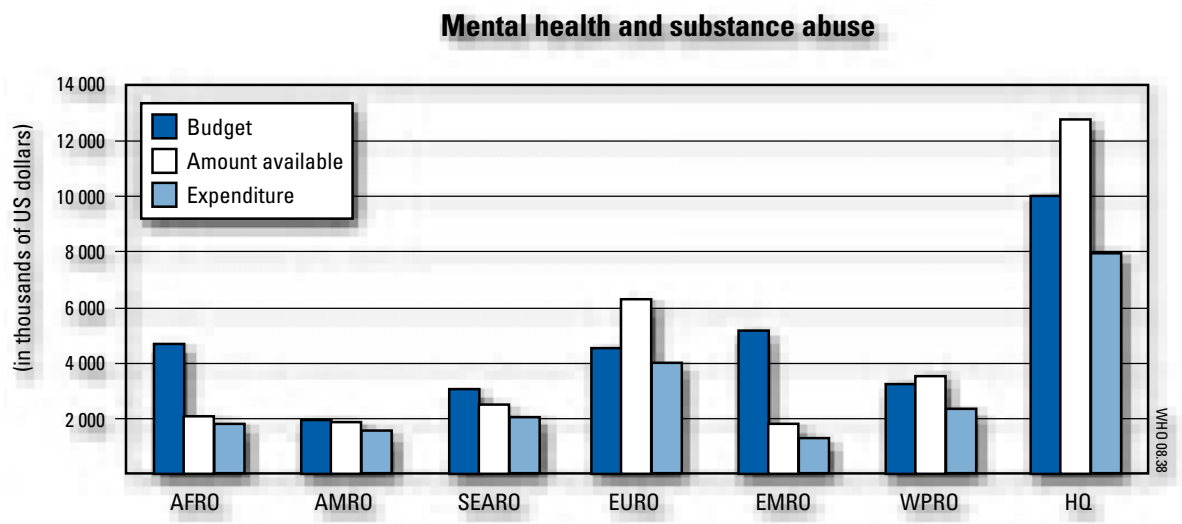
- It is essential that WHO should be able to continue to compile information and evidence and develop normative guidance material in order to achieve its objectives in the area of mental, neurological and substance-use disorders.
- An enhanced WHO presence at subregional level in the person of a subregional adviser has ensured strong support to Member States.
- Emergency and crisis situations provide opportunities for reforming and strengthening mental health systems within countries and regions.
- The human rights of people with mental, neurological and substance-use disorders, and the interface between these disorders and economic and social development, are important areas in which action is required within countries.

Required actions

- WHO should continue to disseminate information, evidence and guidance on mental, neurological, and substance-use disorders globally.
- WHO should give priority to the recruitment of human resources in mental health at subregional level.
- WHO should provide more assistance for mental health in countries affected by emergencies and crises.
- WHO should continue its advocacy for the human rights of people with mental, neurological and substance-use disorders and for developmental issues.

Financial implementation

Mental health and substance abuse												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	2 530	2 150	4 680	1 390	615	2 005	42.8%	1 389	378	1 767	88.1%	37.8%
AMRO	1 537	338	1 875	1 091	731	1 823	97.2%	1 045	478	1 523	83.6%	81.2%
SEARO	1 403	1 597	3 000	1 279	1 235	2 513	83.8%	1 279	743	2 022	80.5%	67.4%
EURO	1 067	3 433	4 500	1 081	5 140	6 221	138.2%	1 081	2 886	3 967	63.8%	88.2%
EMRO	878	4 222	5 100	987	730	1 717	33.7%	987	321	1 308	76.2%	25.6%
WPRO	1 174	2 026	3 200	995	2 487	3 482	108.8%	995	1 278	2 273	65.3%	71.0%
Sub-total Regions	**8 589**	**13 766**	**22 355**	**6 823**	**10 938**	**17 762**	**79.5%**	**6 776**	**6 084**	**12 860**	**72.4%**	**57.5%**
HQ	4 183	5 726	9 909	4 019	8 750	12 769	128.9%	3 962	3 920	7 882	61.7%	79.5%
Total	**12 772**	**19 492**	**32 264**	**10 842**	**19 688**	**30 530**	**94.6%**	**10 738**	**10 004**	**20 742**	**67.9%**	**64.3%**



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Reproductive health (RHR)

WHO objective(s)

To provide the widest achievable range of safe and effective reproductive and sexual health services across the health system and integrate them into primary health care.

Indicator(s) and achievement

- *Number of countries that make reproductive and sexual health an integral part of national planning and budgeting*. The level of interregional variation in the integration of sexual and reproductive health in national planning and budgeting processes remains high. In the Region of the Americas, integration has been achieved in eight countries, whereas in the African Region the number is six. In the Western Pacific, South-East Asia and Eastern Mediterranean Regions, integration is now almost universal.
- *Number of countries reporting at least one of the proxy indicators for use of reproductive and sexual health services*. The majority of countries reported on at least one of the following proxy indicators in the revised framework for monitoring the Millennium Development Goals: proportion of deliveries attended by a skilled health professional (195 countries); antenatal care provided, at least four times, by a skilled health professional (96 countries); contraceptive prevalence (108 countries); and unmet need for family planning (79 countries).

Main achievements

- In 2006, the Fifty-ninth World Health Assembly adopted the WHO Global Strategy for the Prevention and Control of Sexually Transmitted Infections: 2006–2015.[1] In 2007, a global action plan for implementation of the strategy was drawn up, and regional action plans are being developed accordingly.
- Implementation of WHO's first global strategy on reproductive health[2] continued throughout the biennium, including through preparation of country plans. Regional efforts, such as the African Maputo Plan of Action, made an important contribution to country plans.
- The results of a study on female genital mutilation and obstetric outcome were published in 2006 and received much media coverage.
- The WHO/UNFPA Strategic Partnership Programme constituted an important element in WHO's support to countries across all six regions and has met with universal approval in the countries where it has been implemented.
- Global, regional and country estimates of maternal mortality were produced in collaboration with UNICEF, UNFPA and the World Bank.[3]
- Global and regional incidence rates of safe and unsafe abortion were published.[4]

[1] Resolution WHA59.19.
[2] Resolution WHA57.12.
[3] The findings show that, in 2005, 536 000 women died of maternal causes, compared to 576 000 in 1990. The decline in the global maternal mortality ratio was estimated at less than 1% per year between 1990 and 2005. No region achieved the 5.5% annual decline required to achieve Millennium Development Goal 5, although Eastern Asia came closest to the target with a 4.2% annual decline.
[4] The new estimates show that 42 million abortions took place in 2003, down from 46 million in 1995, with nearly half of them (20 million) having been terminated unsafely. Up to 97% of all unsafe abortions occurred in developing countries.

Achievement of Organization-wide expected results

Adequate guidance and support provided to improve sexual and reproductive health care in countries through dissemination of evidence-based standards and related policy, and technical and managerial guidelines

Indicator	Baseline	Target	Achievement
Number of new or updated guidance documents to support national efforts to improve reproductive and sexual health validated and disseminated in countries	Existing portfolio of tools and standards	8 new or updated	16 evidence-based guidance documents were produced and 34 guidance documents were translated into languages other than English

Fully achieved. Support and guidance documents were produced, inter alia, on the following topics: family planning,[5] cervical cancer control,[6] frequently asked clinical questions about medical abortion,[7] male circumcision under local anaesthesia and global trends and determinants of prevalence, safety and acceptability in male circumcision, as well as training and job aid in relation to reproductive choices and family planning for people with HIV in the form of a counselling tool.

New evidence, products and technologies of global and/or national relevance available to improve reproductive and sexual health, and research capacity strengthened as necessary

Indicator	Baseline	Target	Achievement
Number of completed studies of priority issues in reproductive and sexual health	Existing evidence base	40 new studies	35
Number of new or updated systematic reviews on best practices, policies and standards of care	Existing portfolio of systematic reviews	15 new or updated systematic reviews	36
Number of new research centres strengthened through comprehensive institutional development support	More than 100 centres supported by Special Programme of Research Development and Research Training in Human Reproduction since 1972	6 new centres	15

Partly achieved. A Phase III trial of testosterone undecanoate as a male hormonal contraceptive involving over 1000 Chinese couples who used it as their contraceptive method for two years was conducted. The method was considered acceptable: its use did not lead to any serious adverse events. In India, Peru, South Africa and Viet Nam, a randomized, controlled trial on anti-oxidants in the prevention of pre-eclampsia involving 1400 women showed that supplementation with vitamins C and E is unlikely to decrease the risk of pre-eclampsia. A paper on blood pressure dynamics during pregnancy and spontaneous preterm birth, based on the data from the WHO calcium supplementation trial for the prevention of pre-eclampsia in pregnant women with low calcium dietary intake, made an important contribution to the understanding of blood pressure in pregnancy. Grants to enhance research capacity were awarded to 15 new institutions across all regions. As a result of a randomized controlled trial involving 2181 women, new effective approaches to inducing abortion by medical (non-surgical) means were identified.

[5] Family planning: a global handbook for providers. World Health Organization Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP), INFO Project. Baltimore and Geneva, CCP and WHO, 2007.

[6] Comprehensive cervical cancer control: a guide to essential practice. Geneva, World Health Organization, 2006.

[7] Frequently asked clinical questions about medical abortion. Geneva, World Health Organization, 2006.

Policy and technical support effectively provided to countries for the design and implementation of comprehensive plans for increasing access to, and availability of, high-quality sexual and reproductive health care, strengthening human resources, and building capacity for monitoring and evaluation

Indicator	Baseline	Target	Achievement
Number of targeted countries with new or updated strategies and plans for strengthening access to, and availability of, high-quality sexual and reproductive health care	20	20 additional	39
Number of countries completing operational research studies to evaluate approaches to provision of high-quality sexual and reproductive health care	25 in previous two bienniums	15 additional	15

Fully achieved. To reposition family planning in Africa, a "family planning advocacy kit" was introduced through the Implementing Best Practices partnership initiative, in collaboration with the Regional Office for Africa. A conference on scaling up high impact family planning and maternal, newborn and child-health best practices to achieve the Millennium Development Goals in Asia and the Near East was attended by 490 participants from 16 countries who identified the best practices they wished to see scaled up and formulated initial plans. The Implementing Best Practices Knowledge Gateway provided support for collaborative learning and knowledge-sharing through virtual "communities of practice" involving over 10 000 members from 193 countries.

Issue no. 10 of the *WHO Reproductive Health Library* was updated with new reviews and video materials, and published in English, Chinese, French, Spanish and Vietnamese.

Adequate technical support provided to countries for better reproductive and sexual health through individual, family and community actions

Indicator	Baseline	Target	Achievement
Number of targeted countries developing new or improved interventions to foster action at individual, family and community levels for better reproductive and sexual health	0 (new area)	5	17

Fully achieved. Interventions carried out at individual and family levels include health education, communication and counselling activities in support of sexual and reproductive health. At the community level, activities are geared towards increasing community awareness and support for sexual and reproductive health needs and stimulating demand for good-quality services, as well as expanding community involvement in the programme planning cycle. A series of workshops was held in the South-East Asia Region and in eight countries in the Region of the Americas in support of new or improved interventions to foster better sexual and reproductive health actions at individual, family and community levels.

Ability of countries to identify regulatory obstacles to provision of high-quality sexual and reproductive health care strengthened

Indicator	Baseline	Target	Achievement
Number of targeted countries having reviewed their existing national laws, regulations and policies relating to reproductive and sexual health	2	3	18

Fully achieved. A tool for strengthening laws and policies based on human rights for maternal and neonatal health has been applied in Brazil, Indonesia and Mozambique. Reviews of existing national laws, regulations and policies on reproductive and sexual health have been carried out in the African, European and South-East Asia Regions and the Region of the Americas.

International efforts for achieving international development goals in reproductive health, including global monitoring, mobilized and coordinated

Indicator	Baseline	Target	Achievement
Global report on progress towards achievement of international development goals in reproductive health submitted to the Health Assembly	1	2	3 reports[1]

Fully achieved. WHO continued to prepare reports on the sexual and reproductive health situation in selected countries for the various treaty monitoring bodies. To provide practical guidance to WHO staff involved in this process, a handbook on the Convention on the Elimination of All Forms of Discrimination against Women was published. A new interagency statement on the elimination of female genital mutilation was prepared in collaboration with various United Nations agencies and other partners. WHO continued to participate in the Inter-agency and Expert Group on Millennium Development Goal indicators on the development of a new framework, which was presented to the United Nations General Assembly in October 2007. The monitoring framework now includes a new target under Millennium Development Goal 5: "to achieve, by 2015, universal access to reproductive health" with four indicators: contraceptive prevalence, adolescent birth rate, antenatal care coverage, and unmet need for family planning.

Lessons learnt and actions required to improve performance

Lessons learnt

- The WHO Global Strategy for Reproductive Health provided an important impetus and a strong mandate for intensified action in country and regional offices and headquarters.
- Strong coordination with UNFPA, at country level in particular, had a leveraged effect on WHO's technical and policy collaboration with countries in support of sexual and reproductive health.
- Inadequate supplies and unaffordable prices for some sexual and reproductive health commodities remain a critical challenge. Intensified interagency work on reproductive health commodity security will be needed to address this issue.

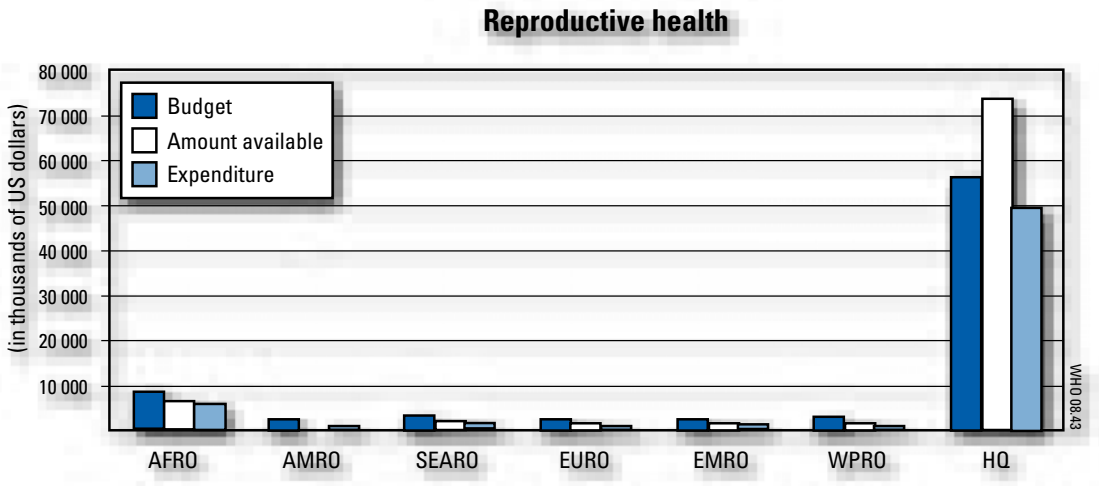
Required actions

- A sustained fund-raising effort is required across the Organization for sexual and reproductive health, including related research.
- A sustained effort is required to scale up the dissemination of research and translate the results into action.
- In order to monitor progress in achieving the Millennium Development Goals and other international development goals related to sexual and reproductive health, existing information systems need to be strengthened and expanded.

[1] Maternal mortality in 2005: estimates developed by WHO, UNICEF, UNFPA, and the World Bank. *Geneva, World Health Organization, 2007;* Unsafe abortion: global and regional estimates of incidence of unsafe abortion and associated mortality in 2003. *5th ed. Geneva, World Health Organization (in press); and Health Assembly progress report on implementation of resolution WHA57.12 on WHO's strategy to accelerate progress in reproductive health.*

Financial implementation

Reproductive health												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	2 925	5 268	8 193	3 046	3 418	6 464	78.9%	3 040	2 560	5 600	86.6%	68.4%
AMRO	1 297	1 076	2 373	841	342	1 183	49.9%	779	219	998	84.3%	42.1%
SEARO	434	2 603	3 037	734	1 298	2 031	66.9%	734	1 140	1 874	92.3%	61.7%
EURO	71	1 829	1 900	231	858	1 089	57.3%	230	680	910	83.6%	47.9%
EMRO	105	2 007	2 112	805	688	1 493	70.7%	805	637	1 442	96.6%	68.3%
WPRO	102	2 918	3 020	168	1 151	1 319	43.7%	169	1 045	1 214	92.0%	40.2%
Sub-total Regions	**4 934**	**15 701**	**20 635**	**5 825**	**7 755**	**13 580**	**65.8%**	**5 757**	**6 281**	**12 038**	**88.6%**	**58.3%**
HQ	3 140	52 797	55 937	3 017	70 339	73 356	131.1%	2 940	46 244	49 184	67.1%	87.9%
Total	8 074	68 498	76 572	8 842	78 094	86 936	113.5%	8 697	52 525	61 222	70.4%	80.0%



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Making pregnancy safer (MPS)

WHO objective(s)

To strengthen national efforts to implement cost-effective interventions so that health systems provide all women and newborn infants with a continuum of care throughout pregnancy, childbirth and the postnatal period.

Indicator(s) and achievement

- *Proportion of women seen by a skilled attendant at least once during the antenatal period*. More than 85% of pregnant women were seen by a skilled attendant at least once during the antenatal period.
- *Proportion of women assisted by a skilled attendant at childbirth*. Globally, about 70% of births are attended by a skilled birth attendant. The increase in the number of women who were assisted by a skilled birth attendant has varied across the six regions. In most European countries, many Asian countries and some Middle-Eastern countries, almost all deliveries are attended by a skilled health professional. However, access to skilled care during childbirth varies considerably between urban and rural areas and between high- and low-income sections of the community.

Main achievements

- There has been greater awareness of, and political commitment to, improving maternal and newborn health, as well as an increase in funding by bilateral donors and countries.
- More well-trained WHO staff dedicated to making pregnancy safer are working in country offices where they are providing timely support to countries.
- More joint planning and monitoring across all organizational levels has improved the coordination of policy formulation, strategy development and technical support to countries.
- National and institutional capacity has been boosted in order to scale up interventions designed to improve maternal and newborn survival and health.

Achievement of Organization-wide expected results

Technical support provided for development of policies, strategies, norms and standards for improving access, quality and use of maternal and neonatal health-care services

Indicator	Baseline	Target	Achievement
Number of countries that established policies, strategies, and adopted WHO norms and standards for improving maternal and neonatal health	20	50	75
Number of countries that have initiated integration of maternal and neonatal health-care services with malaria, HIV/AIDS and nutrition programmes	15	35	37
Number of countries that achieved or are on track to reach the target on the proportion of births attended by skilled health personnel	22	35	More than 80 countries

Partly achieved. Although all three targets were achieved, results still fell short of expectations. This is owing to variability of achievement across regions and countries and heterogeneity in the level of preparedness of health systems in countries which heavily influences quality of care and thus, outcomes for maternal and newborn health. Thailand and Botswana have made progress in the prevention of mother-to-child transmission of HIV as a result of assistance provided through maternal health-care services. Much work still remains to be done to improve access to skilled birth attendants in some countries in the South-East Asia and Western Pacific Regions, and in southern African countries. Many countries, particularly in sub-Saharan Africa, are not on track to achieve the Millennium Development Goal of improving maternal health because of severe shortages, most notably as a result of migration. Rural and poor populations still have very limited access to skilled care during childbirth. The advances that have been made in this area were facilitated by the presence of more designated staff in regional and country offices who provide timely support and follow-up activities. A better understanding and closer collaboration with UNICEF, UNFPA, the World Bank, nongovernmental organizations and professional bodies have improved the timeliness and quality of support being given to countries. WHO has worked closely with the Global Partnership for Maternal, Newborn and Child Health.

Support provided to countries for strengthening monitoring and evaluation systems for maternal and neonatal health programmes and assistance for measuring progress towards the Millennium Development Goals

Indicator	Baseline	Target	Achievement
Number of countries that have established a monitoring system for maternal and neonatal health at national and sub national levels	15	30	50

Partly achieved. While efforts to set up monitoring systems were accelerated and related processes were initiated in many countries, the expected result was only partly achieved. This is owing to the time required to establish, generate and make use of data for informed decision making. Furthermore, monitoring systems and progress measurement require systems to support review, dialogue and technical backstopping. The monitoring of pregnancy, childbirth and its outcomes is increasing in importance. In particular, maternal mortality and the proportion of deliveries attended by a skilled health professional are estimated and published at global level. Training workshops have been conducted to strengthen capacity at district level in the collection, analysis and utilization of data for programme planning. Many countries have begun to conduct maternal death audits in order to improve their maternal and neonatal health programmes. Although levels of achievement vary between regions, all six made progress in providing support to countries for improving their monitoring of maternal and newborn health. Collaborative work with United Nations agencies, including the World Bank, also contributed towards the advances made.

Operations research conducted and evidence gathered to inform implementation of intensified actions towards improving maternal and neonatal health

Indicator	Baseline	Target	Achievement
Number of countries that have engaged in studies relevant to scaling up maternal and neonatal health services	15	30	30

Fully achieved. WHO has worked with universities and institutions in the United States of America and the United Kingdom on different studies, including on the management of postpartum haemorrhage, comparing Misoprostol and Oxytocin, in India. Studies based on the findings of a global survey monitoring pregnancy outcomes at health facilities were carried out in 10 African countries.

Advocacy for political and financial commitment increased and effective partnerships established to support countries in strengthening their maternal and neonatal health services

Indicator	Baseline	Target	Achievement
Number of advocacy events at international, regional and country levels conducted	0	25	35
Number of partnerships with joint action plans for maternal and neonatal health established and/or supported at the global, regional and national levels during the biennium	10	30	38

Fully achieved. Advocacy events organized during the biennium included workshops for female parliamentarians, a workshop for journalists from all branches of the media, and the Women Deliver Conference, held in London in October 2007, which was attended by participants from more than 90 countries, among them 70 ministers and parliamentarians. Through partnerships with UNICEF, UNFPA, the World Bank, regional development banks, international and national nongovernmental organizations, professional bodies, bilateral donors and other institutions, coordinated support was provided to countries to assist them in developing joint action plans. For example, a workshop to improve the coordination of support to countries was organized with assistance from the Swedish International Development Cooperation Agency, which was attended by representatives of UNICEF, UNFPA, the Partnership for Maternal, Newborn and Child Health, the World Bank, regional development banks and high-level officials from 10 countries.

Lessons learnt and actions required to improve performance

Lessons learnt

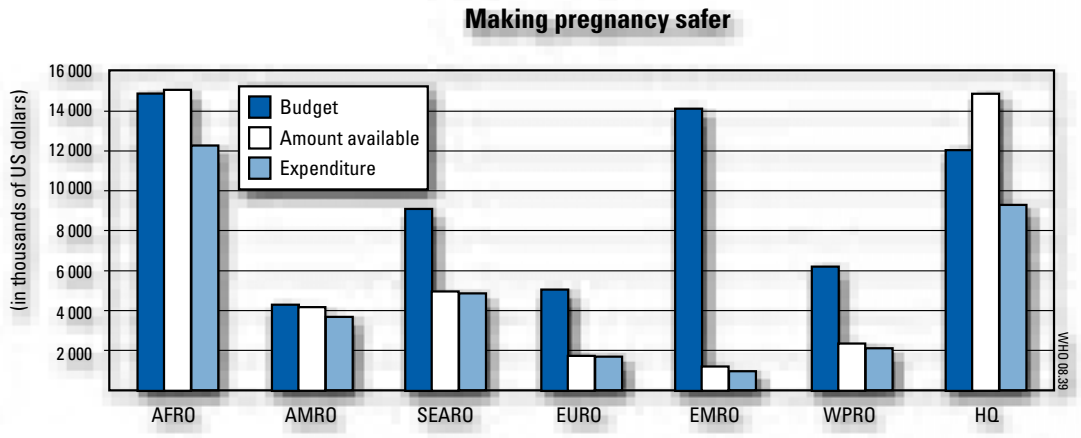
- It is necessary to have enough designated staff at headquarters and in regional and country offices to be able to respond to the policy and technical support needs of countries.
- Effective partnerships make it easier to maximize scarce resources and minimize duplication.
- Working closely with professional bodies, national experts, policy-makers and civil society facilitates the scaling up of interventions to improve maternal and newborn health and survival.
- A transparent joint planning and programme review process at headquarters and in regional and country offices is essential for effective programming and action.

Required actions

- To strengthen the technical capacity of designated staff in regional and country offices and ensure that they are kept abreast of new developments.
- To increase advocacy for maternal and newborn survival and health so that it remains on global, regional and country agendas and attracts adequate investment.
- To increase south-south collaboration through enhanced institutional capacity and the sharing of experiences.
- To further build capacity at district level for monitoring maternal and newborn health programmes and utilizing data for advocacy, programme planning and overall improvement of services.

FINANCIAL IMPLEMENTATION

Making pregnancy safer												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	9 778	5 038	14 816	6 157	8 813	14 970	101.0%	6 151	6 050	12 201	81.5%	82.4%
AMRO	2 769	1 495	4 264	2 694	1 447	4 141	97.1%	2 647	1 007	3 654	88.2%	85.7%
SEARO	5 251	3 749	9 000	3 878	1 099	4 977	55.3%	3 878	1 007	4 885	98.2%	54.3%
EURO	1 242	3 708	4 950	704	1 046	1 750	35.4%	703	991	1 694	96.8%	34.2%
EMRO	2 358	11 643	14 001	569	576	1 146	8.2%	569	392	961	83.9%	6.9%
WPRO	2 038	4 082	6 120	1 753	504	2 258	36.9%	1 754	318	2 072	91.8%	33.9%
Sub-total Regions	**23 436**	**29 715**	**53 151**	**15 755**	**13 485**	**29 240**	**55.0%**	**15 702**	**9 765**	**25 467**	**87.1%**	**47.9%**
HQ	1 421	10 579	12 000	1 366	13 426	14 792	123.3%	1 366	7 856	9 222	62.3%	76.9%
Total	**24 857**	**40 294**	**65 151**	**17 121**	**26 911**	**44 032**	**67.6%**	**17 068**	**17 621**	**34 689**	**78.8%**	**53.2%**



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CHILD AND ADOLESCENT HEALTH (CAH)

WHO objective(s)

To enable countries to pursue evidence-based strategies in order to reduce health risks, morbidity and mortality along the life course, promote the health and development of newborn infants, children and adolescents, and create mechanisms to measure the impact of those strategies.

Indicator(s) and achievement

- *Proportion of cases receiving correct case management of diarrhoea and pneumonia.* 56% of cases of suspected pneumonia taken to an appropriate health provider and 38% of cases of diarrhoea receiving oral rehydration and continued feeding.[1]
- *Proportion of young people having access to health services.* Data collection on this indicator is ongoing and will be analysed and reported in 2010. No global measurement is available for 2007.

Main achievements

- Through the Millennium Development Goals more effort has been directed towards keeping the attention of WHO, partners, and countries focused on commonly-agreed objectives. Monitoring and evaluation efforts have been increased in order to track progress, particularly towards those Millennium Development Goals concerned with child survival, HIV/AIDS and young people, and nutrition.
- National-level strategies have been developed and supported based on regional strategies: the European strategy for child and adolescent health and development, the Child Survival Strategy in the African and Western Pacific Regions, a strategy based on the Integrated Management of Childhood Illness in the Eastern Mediterranean Region and a neonatal health strategy in the Region of the Americas. Most of these strategies are shared with or endorsed by partner agencies, which enhances their effectiveness.
- The Integrated Management of Childhood Illness is expanding significantly in all regions as demonstrated by increased geographical coverage and an increased focus on pre-service training, improved hospital care, newborn health and community-level interventions. The significant contribution made by neonatal deaths to overall under-five mortality has led to a greater focus on newborn health.
- Adolescent health activities at all levels have been expanded following publication of a set of recommendations known as "Steady Ready Go" as part of the WHO Technical Report Series[2] and continuing refinement of the "4-S"strategy, a four-pronged approach encompassing: collating and disseminating strategic information; developing supportive, evidence-informed policies; improving the provision of health services; and forming critical partnerships with other sectors.

[1] State of the world's children, New York, United Nations Children's Fund (UNICEF), 2007. Data from 2000–2006.
[2] Ross, David A. et al. Preventing HIV/AIDS in young people: a systematic review of the evidence from developing countries. Geneva, WHO Technical Report Series: 938, 2006.

At country level, the principal focus has been on adolescent-friendly health services and reaching the most at-risk adolescents.

- Staffing patterns in regional offices reflect the importance WHO is now attaching to this area of work, for example the appointment of child and adolescent health advisers in all regions and national programme officers in an increasing number of countries.

Achievement of Organization-wide expected results

Health-related issues reflected in country reports and recommendations of the Committee on the Rights of the Child, and translated into national policies, strategies and actions

Indicator	Baseline	Target	Achievement
Number of country reports of the Committee on the Rights of the Child that include specific health-related concluding observations and recommendations, reflecting WHO input	10	25	26
Number of countries implementing rights-based needs assessment and capacity building, in order to translate the health-related recommendations into policy, strategy, and action	8	18	21

Fully achieved. A high level of interest in and demand for support in applying child and adolescent rights tools is evident in most regions, in particular in the African and European Regions and in the Region of the Americas. In the latter, participation in all workshops exceeded expectations; the Regional Office for Africa found the tools helpful in supporting countries to align their strategies with the United Nations Convention on the Rights of the Child; countries of the European Region reflect health issues in their reports to the Committee on the Rights of the Child, and the Regional Office for the Western Pacific is promoting the Convention as a programmatic tool. However, limited capacity and resources have restricted WHO's input to the relevant processes.

Technical and policy support provided for the development and implementation of improved policies, strategies, norms and standards for protecting adolescents from disease and from behaviours and conditions that pose a risk to health

Indicator	Baseline	Target	Achievement
Number of countries having developed or implemented evidence-based policy recommendations and guidelines on protecting adolescents from major diseases and from behaviours and conditions that pose a risk to health	30	40	58

Fully achieved. In the European Region, support has been provided to 15 countries for the development and implementation of policies and strategies. Under PAHO's Integrated Management of Adolescent Needs approach, over 300 professionals have been trained and an adolescent-sensitive database has been compiled. The Regional Office for Africa has advanced the implementation of adolescent-friendly health services in 38 countries, and the Regional Office for the Western Pacific has provided direct support to at least six countries and has oriented regional and country staff to the methods and tools available to support the "4-S" strategy. The Regional Office for South-East Asia has drawn up a regional strategy and prepared national profiles and fact sheets on adolescent health.

Some regions now have regional advisers with specific skills and responsibilities in adolescent health and development, but in others they are still awaiting recruitment.

Guidance and technical support provided and research conducted for increased coverage and intensified action towards improving neonatal and child survival, growth, and development

Indicator	Baseline	Target	Achievement
Number of countries that have expanded geographical coverage of Integrated Management of Childhood Illness to more than 50% of targeted districts	25	50	49
Number of countries that have implemented strategies on Integrated Management of Childhood Illness or the Newborn Health Policy and Planning Framework to reduce newborn mortality	7	20	9
Number of countries that have integrated infant feeding counselling (including for infants of HIV-positive mothers) into child health services	30	50	34
Number of research projects supported by WHO that aim at influencing the formulation of strategic norms, standards and guidelines for improving neonatal and child survival	56	70	74

Partly achieved. At least three other regions sent data on child health, but without specifying that it was on newborns.

Countries in all regions have developed child health strategies, most of them based on the Integrated Management of Childhood Illness guidelines, which provide the main platform for reducing child mortality. Emphasis has been placed on increasing geographical coverage in countries with high child mortality ("priority" countries identified by each region). Integrated Management of Childhood Illness activities have expanded from first-level facility care and now include a greater emphasis on hospital care and community interventions. In particular, the Regional Offices for South-East Asia and the Western Pacific emphasized the hospital level, while the Regional Offices for Africa and the Americas highlighted the community level. By designing and implementing an innovative social-actors model, the Regional Office for the Americas has transformed Integrated Management of Childhood Illness activities at community level on a regional basis. The *Pocket book of hospital care for children*[3] has been used in all regions, translated into a number of languages and adapted to country needs.

Newborn health is promoted in a variety of ways. In the European Region, childhood and adolescent health strategies include newborn health. In other regions newborn health has been incorporated into Integrated Management of Childhood Illness activities. In India, UNICEF's Integrated Management of Neonatal and Childhood Illness activities are being implemented. The 47th Directing Council of PAHO adopted a resolution on neonatal health in the context of maternal, newborn, and child health for the attainment of the Development Goals of the Millennium Declaration,[4] and capacity-building workshops on planning for newborn health for regional and country staff were held in the African and South-East Asia Regions. Infant feeding is an integral part of newborn and child health interventions, with special emphasis on the prevention of mother-to-child transmission of HIV. Headquarters has directly supported 12 countries in the use of new WHO tools for newborn and infant feeding, and 40 countries in four regions in the adoption of new recommendations on the treatment of diar-

[3] Pocket book of hospital care for children: guidelines for the management of common illnesses with limited resources. Geneva, World Health Organization, 2005.
[4] Resolution CD47.R19.

rhoea. In all regions the main focus of research projects, which are mainly supported by headquarters, is on interventions to promote newborn health at community level, to provide care for sick children and neonates, to evaluate existing tools for HIV counselling, as well as innovative programmes such as Integrated Management of Neonatal and Childhood Illnesses, and to improve clinical management of childhood illness.

International and national strategies and efforts coordinated in order to attain globally agreed goals for improving child and adolescent health

Indicator	Baseline	Target	Achievement
Number of countries with child-health strategies established to facilitate coordinated action to implement child-health interventions	15	35	30 at time of reporting. However, target is expected to be achieved by the end of the biennium as efforts in a further 23 countries, including some in the Eastern Mediterranean region are well advanced.
Number of countries applying WHO's strategic approach to HIV and young people	10	30	57

Fully achieved. Regional strategies on child survival have proved to be a useful platform for developing national strategies and costing tools have been developed to assist countries in estimating resource needs for their implementation. The value of and need for sustained partnerships in all regions is exemplified by the WHO/UNICEF Child Survival Strategy in the Western Pacific Region; by the WHO/UNICEF/World Bank Child Survival Strategy in the African Region, which is also supported by the African Union; and by the European strategy for child and adolescent health and development, which underlies a complementary strategy being developed by UNICEF. A further 23 countries, including some in the Eastern Mediterranean Region, are drawing up child-health strategies.

Lessons learnt and actions required to improve performance

Lessons learnt

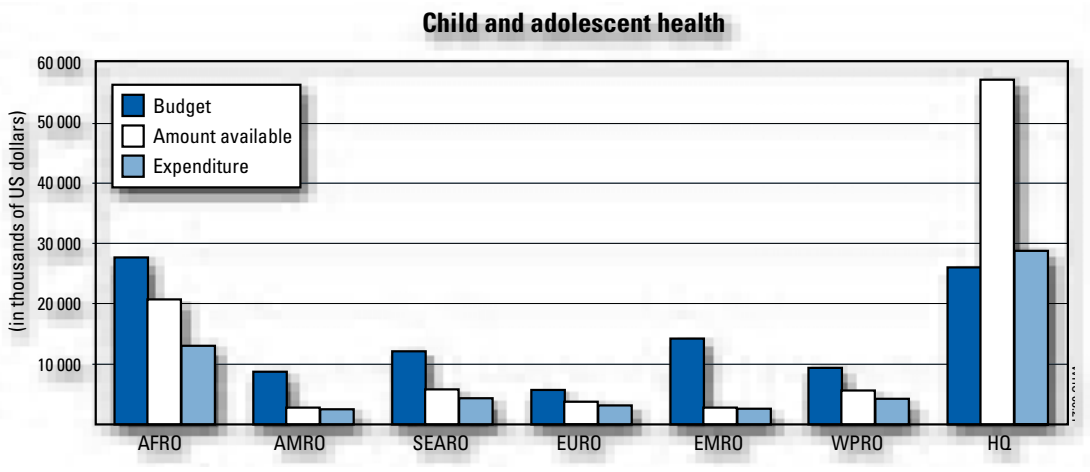
- Regional strategies on child and adolescent health have proved to be a useful platform for developing national strategies, as well as in furthering WHO's work on child and adolescent health.
- Appointing and supporting national programme officers has assisted countries in implementing strategies, as well as in strengthening links between programme areas. Depending on the structure of regional and country offices, the national programme officers may be responsible for newborn and child health, adolescent health, maternal and newborn health, or more than one of these areas.
- Capacity building in programme management at all levels is essential for the integration and scaling-up of effective interventions.
- WHO must continue to generate technical evidence to ensure that the interventions promoted are based on the best available information; this includes analysing the situation in individual countries to support programming.
- Advocacy and partnerships are major factors for promoting child and adolescent health by raising awareness and mobilizing much-needed resources to support government actions.

Required actions

- To support countries in the development of national strategies and implementation of plans of action based on regional strategies. This should be carried out through partnerships wherever possible in order to accelerate the coordination of activities and scale up interventions aimed at meeting the Millennium Development Goals.
- To ensure the continuing presence of suitable staff at regional and country level, including national programme officers in priority countries.
- To build national capacity in programme management in order to support the development, implementation and scaling-up of effective interventions and strategies, including the Integrated Management of Childhood Illness and the "4-S" strategies.
- To expand and strengthen monitoring and evaluation procedures at all levels to allow regular tracking of progress towards attainment of the Millennium Development Goals.
- To continue to support research so that all interventions are evidence-based; this will also enable programmes to focus on health systems in addition to community-level interventions.

Financial implementation

Child and adolescent health												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	8 168	19 332	27 500	5 408	15 214	20 622	75.0%	5 406	7 475	12 881	62.5%	46.8%
AMRO	3 320	5 214	8 534	1 111	1 679	2 790	32.7%	1 079	1 481	2 560	91.8%	30.0%
SEARO	5 541	6 459	12 000	2 794	2 829	5 623	46.9%	2 794	1 680	4 474	79.6%	37.3%
EURO	1 214	4 286	5 500	979	2 964	3 943	71.7%	979	1 961	2 940	74.6%	53.5%
EMRO	2 829	11 178	14 007	1 012	1 674	2 686	19.2%	1 012	1 471	2 483	92.4%	17.7%
WPRO	2 242	7 008	9 250	2 334	3 039	5 373	58.1%	2 334	1 742	4 076	75.9%	44.1%
Sub-total Regions	**23 314**	**53 477**	**76 791**	**13 638**	**27 400**	**41 038**	**53.4%**	**13 604**	**15 810**	**29 414**	**71.7%**	**38.3%**
HQ	4 139	21 527	25 666	3 977	52 985	56 962	221.9%	3 972	24 523	28 495	50.0%	111.0%
Total	**27 453**	**75 004**	**102 457**	**17 615**	**80 385**	**98 000**	**95.6%**	**17 576**	**40 333**	**57 909**	**59.1%**	**56.5%**



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Immunization and vaccine development (IVB)

WHO objective(s)

To promote the development of new vaccines and innovation in biologicals and immunization-related technologies; to ensure greater impact of immunization services, as a component of health delivery systems; to accelerate the control of high-priority vaccine-preventable diseases; and to ensure that the full humanitarian and economic benefits of such initiatives are realized.

Indicator(s) and achievement

- *Number of poliomyelitis cases due to wild-type or vaccine-derived poliovirus*. In 2006 there were 1997 cases, of which 25 were circulating vaccine-derived; in 2007, there were 1181 cases of which 65 were circulating vaccine-derived.
- *Estimated number of measles deaths and cases globally*. In 2006, there were 242 000 estimated measles deaths compared with 439 000 in 2004, and 17 million measles cases compared with 26 million in 2004.
- *Percentage of countries achieving immunization coverage of 80% with three doses of diphtheria-tetanus-pertussis vaccine in all districts*. 88 (46%) of 193 Member States (55 countries reporting district data, and 33 countries not reporting the data but having national coverage ≥ 90%).
- *Coverage of children of less than one year of age with three doses of hepatitis B vaccine*. 60% coverage in 2006 compared with 50% coverage in 2004.

Main achievements

- The Global Immunization Vision and Strategy 2006–2015 was developed and adopted by WHO and UNICEF. It has four main aims: to immunize more people against more diseases; to introduce a range of newly available vaccines and technologies; to provide a number of critical health interventions and surveillance of immunization; and to independently manage vaccination programmes and activities.
- The Global Polio Eradication Initiative made progress as demonstrated by the interruption of indigenous poliomyelitis transmission in Egypt and Niger and the increasing geographical restriction of wild poliovirus in the four remaining endemic countries, namely Afghanistan, India, Nigeria and Pakistan. By the end of 2007, as a result of the Initiative, substantial progress had been made in reducing type 1 poliovirus transmission worldwide, with an 84% decrease in the number of cases during 2006 as a result of using monovalent oral poliomyelitis vaccine type 1.
- In the area of accelerated disease control, progress was made in reducing measles mortality, with global coverage reaching 80%. Measles deaths dropped by 68% between 2000 and 2006, with reductions of 91%, 76% and 81% in the African, Eastern Mediterranean and Western Pacific Regions, respectively. Egypt, 13 Indian states and Zambia were validated as having eliminated maternal and neonatal tetanus, leaving 47 of 58 targeted countries having yet to do so. Thirty-eight

countries have implemented tetanus toxoid supplementary immunization activities in high-risk areas, protecting 12 million women of childbearing age with at least two doses.

- Although global immunization coverage with three doses of diphtheria-tetanus-pertussis vaccine has increased only by 2%, to 79%, coverage in the African Region increased by 7%, reaching 72%. Progress was also made in other regions. Twelve additional Member States attained over 90% coverage, making a total of 114 countries (59%); 72 countries have coverage rates of between 50% and 89%; and only seven countries still have a coverage rate of below 50% (compared to 20 countries in 2000).
- In collaboration with the partners of the Global Alliance for Vaccines and Immunization, a set of activities to accelerate the introduction of new vaccines was identified and WHO's new and underutilized vaccines action plan was developed in order to provide a platform for coordinating such activities in the countries which need these vaccines the most. Eleven more countries introduced hepatitis B and 16 introduced *Haemophilus influenzae* type b (Hib) vaccines in routine immunization, resulting in totals of 164 (85%) and 108 (56%) respectively, out of 193 Member States.
- Following the launch of the global pandemic influenza action plan in order to increase vaccine supply, progress was made in evaluating the most promising strategies, supporting countries to acquire technology to manufacture influenza vaccine, and determining priorities for research. Successful results were obtained in research supported by WHO, including on a conjugate meningococcal A vaccine, developed in partnership with PATH, a catalyst for global health, and a measles aerosol vaccine. A research and development strategy, known as the road map, was established for malaria vaccines. Technical specifications were developed for conjugate pneumococcal vaccines to make them eligible for an innovative financing mechanism, the Advance Market Commitment.
- The WHO Expert Committee on Biological Standardization adopted new standards for two vaccines: human papillomavirus vaccine, a promising new vaccine with considerable potential to prevent illness and death caused by cervical cancer, and for a new meningococcal type A conjugate vaccine against the disease responsible for recurrent epidemics in the "meningitis belt" countries in sub-Saharan Africa. The new standards pave the way for the prequalification and future availability of the human papillomavirus vaccine, and will assist Member States in the evaluation and licensure of candidate conjugate meningococcal A vaccines that are being developed.

Achievement of Organization-wide expected results

Research supported, guidance provided, partnerships built and research and development capacity in developing countries strengthened for the development of vaccines against infectious diseases of public health significance

Indicator	Baseline	Target	Achievement
Number of low- and lower-middle-income countries provided with data supporting evidence-based decisions about vaccine introduction against pneumococcal, rotavirus or human papillomavirus infection that introduced those vaccines early	6 of 34	28 of 34	29 of 34[1]
Number of priority developing countries with improved preparedness for introduction of HIV vaccine	10 of 32	15 of 32	21 of 32

Fully achieved. An action plan has been prepared which defines correlates of protection for dengue vaccines, and a partnership agreement has been signed with the Paediatric Dengue Vaccine Initiative. Clinical guidelines have also been drawn up for dengue and enterotoxigenic *E. coli*. An Organization-wide workplan has been developed on the introduction of human papillomavirus vaccine and the phase 2 trial of conjugate meningitis A has been completed in Gambia and Mali. Two Japanese encephalitis vaccines for paediatric use are being produced in developing countries, and at regional level, guidelines have been prepared for the introduction of Japanese encephalitis vaccine and laboratory diagnosis methods. A phase 1 trial of a malaria vaccine candidate was completed in China. Data for pneumococcal and Hib disease-burden were modelled, and cost-effectiveness models developed for rotavirus and human papillomavirus. At the Fourth Forum of the African AIDS Vaccine Programme, a WHO-supported network of African stakeholders dedicated to the accelerated production of an HIV vaccine for Africa received significant political support. Three technical guidance documents on ethics and regulatory research on HIV vaccines and a tool to estimate the cost-effectiveness of delivery strategies were finalized. The sustained support of partners has facilitated much of the work done, but more might have been accomplished had human and financial resources been less constrained.

Norms and standards set for production control and regulation of vaccines and other biologicals, and reference standards established

Indicator	Baseline	Target	Achievement
Proportion of priority vaccines and biologicals for which necessary regulatory research is under way or which have production and quality-control recommendations; establishment of candidate reference materials	3 (20%) of 15 for priority vaccines and biologicals; 30% for studies on candidate reference materials from 4 WHO regions	15 (100%) of 15 for priority vaccines and biologicals; 50% for studies on candidate reference materials from 4 WHO regions	19 standards and reference materials generated for priority vaccines; 50% for studies on candidate reference materials from 4 WHO regions

Fully achieved. Four more standards have been generated in addition to the 15 planned. Written standards prepared by the WHO Expert Group on Biological Standards included: guidelines for pandemic influenza preparedness; revised recommendations for inactivated Japanese encephalitis vaccines; revised recommendations for clinical evaluation of meningococcal C vaccines; guidelines for human papillomavirus vaccines; recommendations for meningococcal A conjugate vaccines; and guidelines for stability evaluation of vaccines. Work has begun on guidelines for the regulation of biosimilar products and strategies for the implementation of international standards targeting different levels of users. A database of international standards, which is to be regularly reviewed, has been established in collaboration with other standard-setting bodies.

Capacity in countries to implement policies and to ensure that immunization programmes use vaccines of assured quality and implement safe immunization practices adequately strengthened through technical and policy support

Indicator	Baseline	Target	Achievement
Proportion of Member States in which the national immunization programme uses only vaccines of assured quality (according to WHO criteria)	123 (64%) of 192	150 (78%) of 192	177 (92%) of 193 Member States
Proportion of countries assuring sterile injection practices (according to WHO algorithm)	132 (80%) of 165 target countries	165 (100%) target countries	WHO algorithm is no longer used. Indicator currently monitored is "proportion of countries using auto-disable syringes for immunizations". Indicator status: 78 (40%) of 193 Member States using auto-disable syringes compared with 63 (33%) at the beginning of the biennium

Partly achieved. The number of countries using vaccines of assured quality increased by 54 (28%). A major success factor is an improvement in the functioning of regulatory systems through the establishment and strengthening of national regulatory authorities, which has resulted in an increase in the number of manufacturers, particularly in the developing world. In recognition of the need to support national regulatory authorities in their assessment of clinical trial applications and monitoring of clinical trials, WHO has initiated the African Vaccine Regulatory Forum, which is intended to serve as a source of expertise for countries when making regulatory decisions for which they may not have the capacity or expertise. Two meetings have been held, a plan of action agreed and joint regulatory activities for 2008 identified. Fifteen (7%) more Member States started to use auto-disable syringes in routine immunizations, with remarkable progress being made in the South-East Asia Region, where all countries use auto-disable syringes except Thailand, which uses disposables. In the African Region, 89% of countries use auto-disable syringes, and 64% of countries in the Eastern Mediterranean Region and 63% of countries in the Western Pacific Region use them. A Performance, Quality and Safety system was established to place increased emphasis on applying international standards and quality assurance in the manufacturing process, and to take account of feedback from the field. The system was used to release product specifications and verification protocols for immunization equipment, including safety boxes, cold rooms, freezer rooms and temperature monitoring devices. Progress in decentralizing activities has been slow and human and financial resources remain limited. A high level of technical competence has been maintained throughout the Organization and support has continued to be provided to regions and countries for building capacity. There has also been an increase in the political commitment of many Member States.

Capacity of countries to assure the security of vaccines supply and to increase the financial sustainability of the national immunization programmes adequately strengthened through technical and policy support

Indicator	Baseline	Target	Achievement
Proportion of targeted countries that have prepared and are implementing a financial sustainability plan	32 (42%) of 75	41 (55%) of 75	Countries moved from financial sustainability plans to costed comprehensive multiyear plans. 63 countries developed comprehensive multiyear plans

Fully achieved. Extensive capacity-building activities were carried out in the regions for the transition to comprehensive multiyear plans and vaccine procurement. Intercountry workshops were also conducted on the findings of and lessons learnt from debt relief initiatives. Phase 2 of the new vaccines co-financing policy of the Global Alliance for Vaccines and Immunization was finalized and a questions and answers paper prepared for regional and country use. A vaccine procurement assessment tool was developed and tested in six countries, and in cooperation with the Regional Office for Africa, initial consideration was given to a revolving fund and pooled procurement system for vaccines. Technical support and extensive capacity-building activities continued to be made available through close collaboration between WHO offices, the effective engagement of national counterparts, commitment by national authorities, and the sustained involvement of partners. A timely start in providing support to regional and country activities was hampered by delays in the arrival of funding. Because financial resources were restricted to countries eligible for support from the Global Alliance for Vaccines and Immunization, only limited assistance and incentives were available to non-eligible countries for developing comprehensive multiyear plans. Financial sustainability remains a challenge for many countries, especially in view of the availability of newer and more expensive vaccines.

Capacity in countries to ensure effective monitoring of immunization systems and assessment of disease burden related to vaccine-preventable diseases adequately strengthened through technical and policy support

Indicator	Baseline	Target	Achievement
Proportion of Member States meeting targets for completeness of surveillance reporting from districts to national level	96 (50%) of 192	153 (80%) of 192	The indicator was monitored using the WHO/UNICEF Joint Reporting Form and, by common agreement, was removed from the Form at the 2006 revision. An alternative indicator, Member States providing timely and complete information to WHO using the Joint Reporting Form, was met by 115 (60%) of 193 Member States (compared to 83 (43%) at the beginning of the biennium)
Proportion of Member States with access to accredited laboratory for testing of measles specimens	96 (50%) of 192	153 (80%) of 192	178 (90%) of 193 Member States have access to accredited laboratories; 161 (83%) Member States have proficient laboratories and 189 (98%) countries have access to these laboratories

Fully achieved. A global framework for immunization monitoring and surveillance – a new comprehensive approach to meeting the challenges in vaccine-preventable disease surveillance and immunization programme monitoring – was developed by WHO and the United States Centers for Disease Control and Prevention in response to the need for timely and valid epidemiological and programme information, which is crucial for measuring progress towards meeting immunization goals and control-

ling vaccine-preventable diseases. Aimed at public health planners and donors, the new global framework provides guidance on integrating surveillance and programme monitoring into national public health systems, building surveillance and monitoring capacity at country level by expanding existing systems, and providing high-quality data for monitoring the performance of immunization programmes. The number of Member States having access to accredited laboratories for testing measles specimens almost doubled. Expansion of the measles/rubella laboratories network and its integration in other disease networks continues; it now encompasses 688 laboratories worldwide. Capacity-building training courses for laboratories are being conducted in all regions. The continued support of partner agencies and commitment by country and regional offices, coupled with the existence of agreed standardized and joint reporting requirements, have all contributed towards the progress made.

Access to current, new and underutilized vaccines maximized and disease-control efforts accelerated in countries and areas by the provision of technical and policy support that effectively contributes to build capacity from district level upwards

Indicator	Baseline	Target	Achievement
Proportion of the infant cohort in all Member States protected by three doses of hepatitis B vaccine	68%	84%	60%. Actual (rather than projected) baseline:[2] 50%
Proportion of Member States achieving >80% immunization coverage with three doses of diphtheria-pertussis-tetanus vaccine at district level in all districts or equivalent subnational administrative level	96 (50%) of 192	134 (70%) of 192	88 (46%) of 193 Member States (55 reporting district data and 33 not reporting the district data, but having national coverage ≥ 90%). Actual baseline: 77 (40%) Member States (51 reporting district data and 26 not reporting the district data, but having national coverage ≥ 90%)
Proportion of targeted Member States having eliminated maternal and neonatal tetanus	15 (26%) of 57	28 (49%) of 57	11 (19%) of 58 targeted countries[3] and 13 Indian states. Actual baseline: 9 (16%) of 57 countries and zero Indian states
Proportion of Member States achieving 90% childhood immunization coverage against measles	134 (70%) of 192	173 (90%) of 192	114 (59%) of 193 Member States. Actual baseline: 97 (51%) Member States

Partly achieved. Eleven more countries introduced hepatitis B vaccination making a total of 164 (85%) of 193 Member States. Assistance was provided to countries for preparing applications for hepatitis B, Hib, yellow fever, pneumococcal and rotavirus vaccines, resulting in 46 applications approved for support by the Global Alliance for Vaccines and Immunization. Despite an increase of only 6% for the "reaching every district" indicator, which monitors the proportion of Member States achieving more than 80% diphtheria-tetanus-pertussis vaccination coverage in all districts, there was an increase in the number of districts in each country attaining such coverage. In 2006–2007, maternal and neonatal tetanus surveys were conducted in Egypt, 13 Indian states, Mali, Nigeria, the United Republic of Tanzania and Zambia, as a result of which Egypt, the Indian states and Zambia were validated as having achieved elimination. During the biennium, an 80% global coverage rate for the first dose of measles vaccine was reached and measles deaths worldwide fell by 60%. This public health achievement is the result of major national immunization campaigns, including mass supplementary immunization activities, and better access to routine childhood immunization. The high quality of the measles campaigns was achieved through the support of field staff and integrated activities carried out with other WHO programmes, such as polio and malaria. The contribution of resources, advocacy and technical assistance by partners plays a major role in moving closer to the goal of elimination, as well as in

accelerating the introduction of new vaccines. The availability and use of combination vaccines containing hepatitis B and Hib antigens, coupled with support from the Global Alliance for Vaccines and Immunization for the introduction of these vaccines in eligible countries, have stimulated the rapid increase in coverage with these antigens. Sustaining the level of resource commitment to maintain and build on the gains made in measles mortality reduction is a challenge; the gap between the available data and those required for decision-making, competing priorities and the high price of new vaccines all result in delays in the introduction of new vaccines.

Effective coordination and support provided to interrupt circulation of any reintroduced poliovirus, to achieve certification of global poliomyelitis eradication, to develop products for the cessation of oral poliovirus vaccine and to integrate the Global Polio Eradication Initiative into the mainstream of health delivery systems

Indicator	Baseline	Target	Achievement
Number of countries and areas having reported endemic poliomyelitis during the previous three years in conditions of certification-standard surveillance	6	0	4
Proportion of countries with all laboratories containing wild-type poliovirus and vaccine production facilities meeting Biosafety level 3 poliomyelitis requirements	53 (25%) of 215 reporting countries	215 reporting countries (100%)	157 (73%) of 215 reporting countries (number of countries completing phase I). Implementation of Biosafety level 3 containment is not required until one year after the last wild poliovirus case is reported globally. Due to continuation of wild poliovirus circulation in endemic countries, the focus of containment remains completion of phase I
Proportion of suspected poliomyelitis cases investigated and responded to through the Global Outbreak and Alert Response Network	25% of events	100% of events	47% of events

Partly achieved. By the end of 2007 the number of poliomyelitis-endemic countries had decreased from six to four: Afghanistan, India, Nigeria and Pakistan. Endemic transmission was interrupted in Egypt, and in Niger endemic transmission was interrupted, but sporadic cases of imported wild poliovirus from neighbouring Nigeria continued to be reported. Progress has been made in the remaining poliomyelitis-endemic countries: continuing restriction of the disease to specific, geographically-limited areas; zero reporting of type 1 poliomyelitis cases in 2007 in western Uttar Pradesh, India, historically the largest poliomyelitis reservoir in the world; an almost 90% reduction in type 1 poliovirus in northern Nigeria between 2006 and 2007; a 25% reduction in the number of missed children in southern Afghanistan between mid- and late 2007 despite the insecurity; and elimination of endemic poliomyelitis in the most densely populated areas of Pakistan, which now reports only sporadic imported cases. To prepare for Biosafety level 3 containment, countries have been requested to identify facilities that have the necessary materials, to destroy those that are no longer needed, and to prepare for containment when interruption of transmission is imminent. In the three WHO regions certified as poliomyelitis-free, 95% of countries have completed these preparations. In poliomyelitis-endemic regions, where the focus remains on interrupting transmission, 65% of countries have completed preparations. Cases of acute flaccid paralysis continue to be detected, investigated and responded to through national designated surveillance systems, with data reported to WHO on a weekly basis and further consolidated at regional and global levels. A total of 141 531 cases of acute flaccid paralysis were detected and reported globally through this system

in 2006–2007. Thirty-four outbreaks occurred in previously poliomyelitis-free areas and 47% of these were noted on the Global Outbreak and Alert Response Network outbreak verification list. Close collaboration between WHO offices, coupled with the effective engagement of national counterparts, have been essential components in achieving the above results; for example, coordination between country programmes, laboratories and all stakeholders played a crucial role in allowing early diagnosis and control of poliomyelitis importations and outbreaks. The sustained support of partners at all levels for the main initiatives remains a key factor in achieving the goal of eradication, while the gap between needs and the available resources, as well as maintaining the necessary level of resource commitment and focus in poliomyelitis-free countries, are challenges that need to be overcome.

Lessons learnt and actions required to improve performance

Lessons learnt

- The provision of clear and effective strategies and policy recommendations is imperative. The Global Immunization Vision and Strategy 2006–2015, together with the development of regional strategic plans and countries' comprehensive multiyear plans for immunization, should lead to an overall improvement in performance.
- National commitment and ownership of immunization and vaccine development need to be ensured as they are the key elements in achieving immunization goals.
- Joint planning and close coordination between headquarters and regional and country offices have facilitated the implementation of activities and should be further enhanced.
- Appropriate and high-quality disease surveillance systems should be established and maintained through appropriate modifications in immunization and vaccine development to encourage well-reasoned decision-making, early detection and timely responses to disease control problems.
- The value added by partnerships with governments and multilateral, private and social organizations contributes to social mobilization, advocacy and overall quality assurance. Maintaining and potentially increasing the level of such commitment is essential.
- The implementation of integrated activities by partner agencies and WHO improves efficiency. The level of such integration should be sustained and possibly enhanced in order to provide support for other disease control and elimination initiatives, by, for example, a better use of the infrastructure created under the poliomyelitis eradication initiative.

Required actions

- Support to countries should be enhanced through the provision of policy and strategic guidance and the strengthening of capacity through initial and follow-up training.
- The levels of core staff and financial resources need to be maintained in countries in order to achieve regional and global immunization goals.
- Implementation of a resource mobilization strategy, together with effective advocacy and communication activities, is needed to ensure sufficient and sustainable financial resources. Broader cooperation with current partners and donors and the active involvement of new partners and donors should be pursued, including at country level.

- For poliomyelitis eradication, maintaining acute flaccid paralysis certification-standard surveillance in all Member States is essential in order to ensure an effective outbreak response to any wild poliovirus importation into a poliomyelitis-free area. Minimizing the consequences of such importation requires routine poliomyelitis immunization coverage to be maintained at more than 80% in all Member States. The risk of a reintroduction of wild poliovirus can be reduced by completing the measures set out under phase I of the WHO global action plan for laboratory containment of wild poliovirus in the 39 poliomyelitis-free countries that have yet to implement them. Eradication strategies may need to be modified in order to overcome specific difficulties in reaching all children in each of the remaining endemic transmission zones.
- For measles, quality follow-up campaigns and catch-up immunization, particularly in the South-East Asia Region, as well as the strengthening of laboratory and surveillance systems, should be continued to further improve routine immunization coverage levels and achieve the next goal in measles mortality reduction. Efforts should be maintained to sustain the results achieved so far, as well as resources and technical commitment at all levels.
- The strengthening of capacity for informed decision-making, disease surveillance and logistics and vaccine management at regional and country levels is required to facilitate the introduction of new life-saving vaccines such as pneumococcal and rotavirus vaccines.

[1] The denominator is a set of 34 countries that were considered as being likely to introduce one of the three vaccines on the basis of historical trends. The numerator represents the number of countries that have made a firm decision on an introduction date according to information provided by the Global Alliance for Vaccines and Immunization.

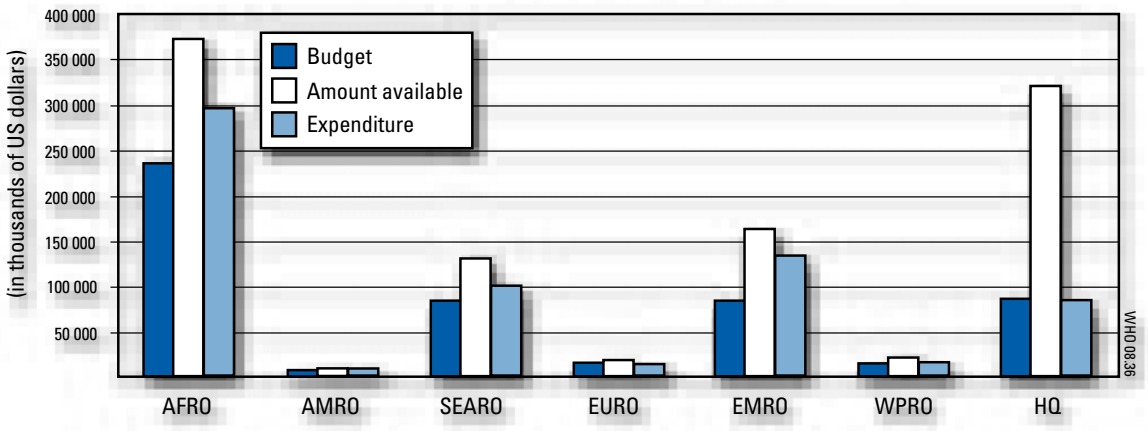
[2] The baseline projections were made in April 2004 and represent expectations of what would be achieved by the beginning of 2006. "Actual baselines" reflect the status of indicators at the beginning of 2006 and are necessary for measuring biennial progress.

[3] The denominator changed from 57 to 58 during the biennium with the inclusion of Timor-Leste.

FINANCIAL IMPLEMENTATION

Immunization and vaccine development												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	902	234 378	235 280	2 509	371 055	373 564	158.8%	2 508	293 325	295 833	79.2%	125.7%
AMRO	1 558	6 240	7 798	1 658	9 160	10 818	138.7%	1 642	6 269	7 911	73.1%	101.4%
SEARO	1 513	83 124	84 637	2 714	127 904	130 618	154.3%	2 714	96 561	99 275	76.0%	117.3%
EURO	791	14 022	14 813	742	18 231	18 974	128.1%	743	14 100	14 843	78.2%	100.2%
EMRO	1 453	82 304	83 757	1 457	161 055	162 512	194.0%	1 457	131 937	133 394	82.1%	159.3%
WPRO	1 564	13 239	14 803	1 703	20 020	21 723	146.7%	1 703	15 915	17 618	81.1%	119.0%
Sub-total Regions	**7 781**	**433 307**	**441 088**	**10 784**	**707 425**	**718 209**	**162.8%**	**10 767**	**558 107**	**568 874**	**79.2%**	**129.0%**
HQ	6 590	79 062	85 652	6 333	314 988	321 321	375.1%	6 322	78 383	84 705	26.4%	98.9%
Total	**14 371**	**512 369**	**526 740**	**17 117**	**1022 413**	**1039 530**	**197.4%**	**17 089**	**636 490**	**653 579**	**62.9%**	**124.1%**

Immunization and vaccine development



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Emergency preparedness and response (EHA)

WHO objective(s)

To develop and implement policies, programmes and partnerships that increase the capacity to prepare, respond and mitigate the risks to health during crises, and support recovery and sustainable development.

Indicator(s) and achievement

- *Number of Member States with which WHO has partnerships for disaster risk reduction, preparedness, response and recovery*. As part of the Humanitarian Reform, WHO and numerous partners from inside and outside the United Nations system have formed the Global Health Cluster, which was activated in ten acute onset emergencies and eight ongoing emergencies.

Main achievements

- Within the humanitarian reform framework, WHO acts as lead agency in the Global Health Cluster, which comprises between 30 and 40 United Nations and non-United Nations humanitarian partners. WHO actively participates with the different bodies within the Inter-Agency Standing Committee and has developed good working relations with humanitarian donors. It is also an active partner in the International Strategy for Disaster Reduction.
- Emergency preparedness, response and recovery capacity in country offices and sub-offices in the African and Eastern Mediterranean Regions has been reinforced, particularly in countries affected by crises. WHO's presence in countries and participation in interagency actions, such as joint assessments and regional workshops, and its efficient coordination methods have increased interagency acceptance of WHO's role as Health Cluster lead agency.
- Technical intercountry activities to enhance disaster risk reduction and improve disaster management capacity in the health sector have been undertaken in all regional offices.
- Standard operating procedures for health emergencies and internal managerial and administrative arrangements have been revised and a new surge capacity mechanism established in order to be able to mobilize technical expertise and respond more effectively to health crises.
- The production and distribution of print and multimedia materials on all aspects of disaster preparedness, mitigation and response has continued in all regions.

Achievement of Organization-wide expected results

Operational presence in countries strengthened in order to collaborate with Member States and stakeholders in preparing and responding to the health aspects of crises and in formulating and implementing recovery, rehabilitation and mitigation policies

Indicator	Baseline	Target	Achievement
Number of countries with preparedness, response and mitigation programmes in place	84	119	118
Number of WHO country offices meeting agreed standard performance level for health action in crises	30	50	More than 50
Percentage of crises in which preparedness measures were taken and adequate response was given, in accordance with agreed levels	40	50	60%

Partly achieved. The disaster preparedness and response operational presence in priority countries has been sustained over the biennium, mainly through funding from three-year programme sources. More than 50 country offices have met the agreed performance level for health action in crises, both in acute onset emergencies, ongoing emergencies and transition situations, mainly thanks to the increase in the number of emergency preparedness and response focal points at country level. In all regions, meetings were held with WHO Representatives and regional office staff to discuss the standard performance level for health action in crises, as well as implementation of the health cluster approach. Support was provided to country offices in the form of technical and financial management backstopping of response and recovery projects. WHO oversaw global, regional and country input for the formulation of the Consolidated Appeals Process. Between 12 and 13 consolidated appeals were launched in both 2006 and 2007. The Consolidated Appeals Process is the main tool for mobilizing resources in countries in transition or experiencing chronic emergencies. Technical support in the form of mentoring, training and supervision was provided to countries in the recovery and transition phase in order to assist WHO staff and their counterparts and partners at country level to collect, analyse and utilize relevant information for the formulation of policies and strategies, and for planning relevant health interventions. WHO staff throughout the world shared project and grant management tools, guidelines and training materials, as well as financial tracking tools adapted to needs in the field. Having dedicated emergency health action focal points based in priority countries has helped Member States to strengthen their emergency preparedness and response capability. A lack of financial resources impedes any further enhancing of operations in emergency and crisis situations.

Greater emphasis on health issues within humanitarian activities through increased WHO participation and visibility in United Nations and interagency coordination mechanisms for disaster preparedness and response

Indicator	Baseline	Target	Achievement
Number of times WHO is represented in crisis – and disaster – assessment missions	18	36	39
Number of coordination mechanisms dealing with health in crisis at country, regional and global levels run or supported by WHO	30	40	50

Fully achieved. Since the last quarter of 2006, the Global Health Cluster has made progress in building partnerships and increasing inclusiveness and collaboration. WHO has acted as lead agency in the Health Cluster in eight chronic protracted emergencies and eight acute crises. It has coordinated the Health Sector Group in approximately 35 country or regional crises where the cluster approach has not yet been implemented, and has led the funds appeal for displaced Iraqis in neighbouring countries. However, there is a need for additional training in, as well as support for, the cluster approach, the Central Emergency Response Fund (CERF), Flash appeals and other United Nations procedures that may be activated in the immediate aftermath of an emergency. Promoting the objectives of the humanitarian reform process through the cluster approach in order to improve predictability in humanitarian response operations and identify clear responsibilities for cluster lead agencies is proving a serious challenge. WHO has also convened national and regional networking meetings to strengthen coordination in preparedness and response. The health cluster framework encourages inclusiveness and participation by allowing partners to tailor their commitment according to their interests and capacity, and there is now a satisfactory level of coordination within the Health Cluster at country and global level. However, the large number of players involved in health that work bilaterally with governments, and the inability of other United Nations agencies to prioritize health issues or recognize the potential of some to become major problems in emergencies, are limiting the impact of Health Cluster interventions, as well as participation by WHO in preparedness and response work. Therefore, both coordination and advocacy during the pre-crisis period need to be intensified.

WHO's capacity increased to support Member States' prompt and effective response to a wide range of health crises

Indicator	Baseline	Target	Achievement
Proportion of times rapid response teams deployed within 24 hours after a declaration of emergency	20%	80%	90%

Fully achieved. WHO has responded promptly to acute onset emergencies by implementing the cluster approach and preparing the health components of Flash appeals. Public health pre-deployment courses, which prepare external experts and WHO staff for health emergency response operations, were conducted in Geneva and Moscow. The establishment of regional contingency funds to facilitate a timely response to potential health needs in future emergencies and health crises affecting Member States would further improve regional response capacity. Administrative procedures need to be further streamlined to ensure prompt and effective action in emergencies and disasters.

Systems and standard operating procedures for emergencies established, to permit a rapid and dependable response that emphasizes the health priorities of populations at risk from, or affected by, natural disasters, complex emergencies and protracted crises

Indicator	Baseline	Target	Achievement
Number of standard operating procedures for emergencies agreed and implemented	5	20	30

Fully achieved. The emergency standard operating procedures were developed by administrative and operational staff at all three levels of the Organization following the launching of a consultative process at a global workshop in Geneva in August 2006. Participants from headquarters and regional and country offices identified the

main impediments to WHO's work in crises, made recommendations for overcoming them, and developed a workplan for drawing up the emergency standard operating procedures. A global initiative has been launched to upgrade WHO logistics capacity in collaboration with the United Nations World Food Programme. Tools and guidance developed with the Global Health Cluster include, an initial rapid assessment tool and a stakeholder mapping and health service availability tool, and guidance on gap analysis, health in recovery, and building the preparedness capacity of national stakeholders. In late 2007, work began on a Health Cluster pocketbook containing guidance on key stages of emergency response that will provide references to all the common guidance and tools available within the Global Health Cluster and serve as a common document for all Health Cluster partners. The standard operating procedures were drafted, circulated to all working groups, approved and adopted between September and October 2006. They should allow support to be provided to Member States more quickly. There has been an ongoing effort to develop regional guidance and references for providing technically sound assistance in emergencies. The toolkit for Health Cluster operations provides a ready guide for implementing response activities.

Lessons learnt and actions required to improve performance

Lessons learnt:

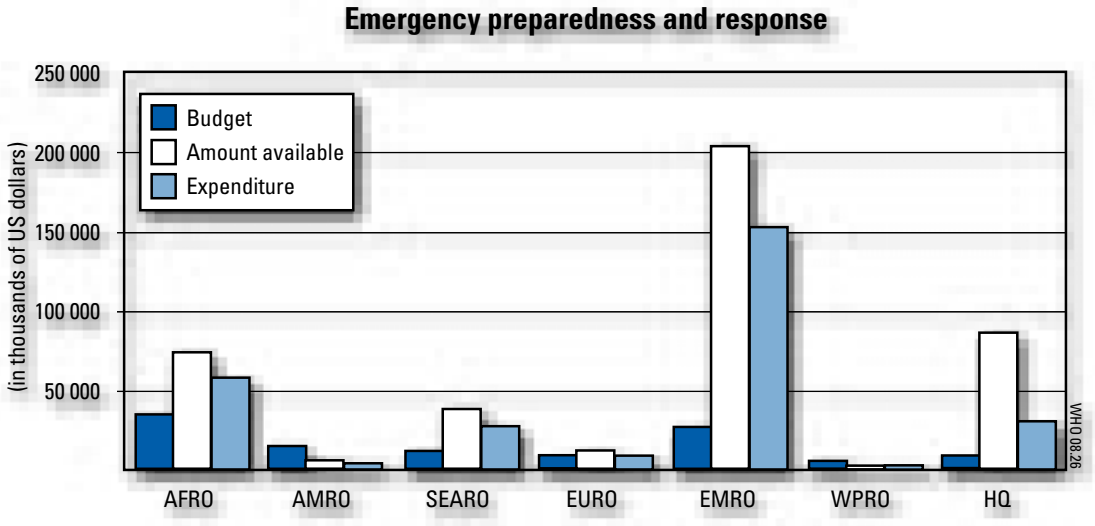
- Some of the planned products for preparedness were only partially achieved because of staff shortages.
- Promoting the implementation of a comprehensive multi-hazard, multisectoral approach versus a specialized vertical technical approach is still proving a challenge.
- There is a discrepancy between growing demand created by Member States selecting disaster preparedness and response as a priority area and the limited resources available for operational investments.
- The rapid assessment of post-disaster health requires better information management.

Required actions:

- Tools are needed for assessing the impact of emergencies on health systems and assisting countries in developing recovery programmes for health in the wake of an emergency.
- Implementation of the United Nations humanitarian reform process and the cluster approach requires a further upgrading of institutional capacity and readiness at all levels of the Organization in order to meet the demands of future health crises.
- As Health Cluster lead agency, WHO needs to strengthen its coordination capacity at country level.
- The new standard operating procedures for emergencies need to be formally endorsed and adopted at global and regional level, communicated to country offices and further promoted through regional training initiatives, including drills and simulation exercises.

Financial implementation

Emergency preparedness and response												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	2 236	32 752	34 988	3 127	70 275	73 401	209.8%	2 996	54 951	57 947	78.9%	165.6%
AMRO	417	13 926	14 343	500	5 103	5 603	39.1%	464	3 408	3 872	69.1%	27.0%
SEARO	1 728	9 198	10 926	2 362	35 423	37 785	345.8%	2 362	24 731	27 093	71.7%	248.0%
EURO	778	7 477	8 255	645	10 592	11 237	136.1%	645	8 384	9 029	80.4%	109.4%
EMRO	1 141	25 707	26 848	1 472	201 885	203 357	757.4%	1 472	150 453	151 925	74.7%	565.9%
WPRO	450	4 762	5 212	404	2 248	2 652	50.9%	403	2 039	2 442	92.1%	46.9%
Sub-total Regions	**6 750**	**93 822**	**100 572**	**8 509**	**325 526**	**334 035**	**332.1%**	**8 342**	**243 966**	**252 308**	**75.5%**	**250.9%**
HQ	2 285	6 580	8 865	2 345	83 268	85 613	965.7%	2 324	27 388	29 712	34.7%	335.2%
Total	**9 035**	**100 402**	**109 437**	**10 854**	**408 794**	**419 648**	**383.5%**	**10 666**	**271 354**	**282 020**	**67.2%**	**257.7%**



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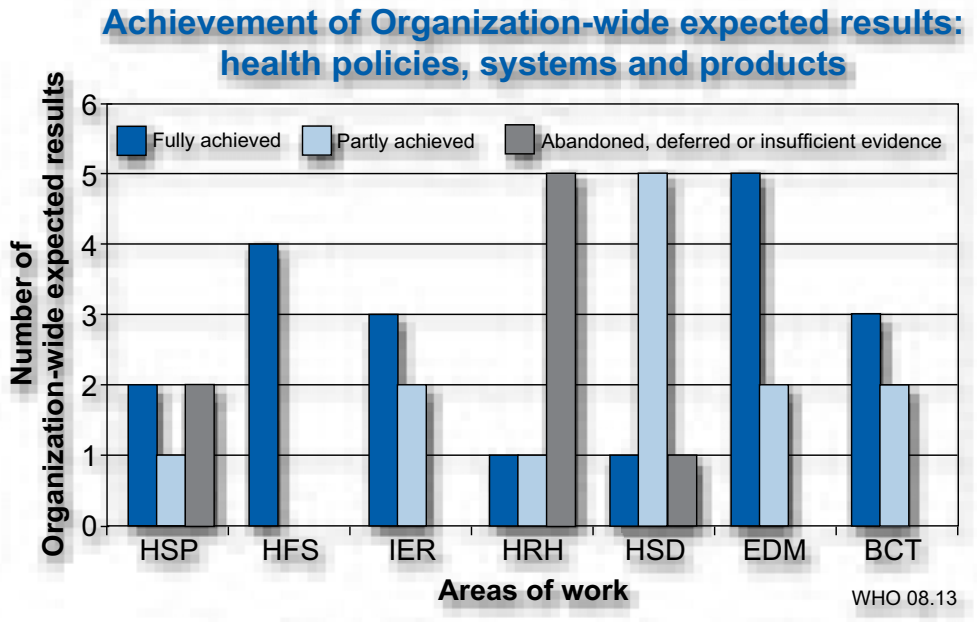
Health policies, systems and products

The Health policies, systems and products grouping comprises the following areas of work: Health system policies and service delivery (HSP); Health financing and social protection (HFS); Health information, evidence and research policy (IER); Human resources for health (HRH); Policy-making for health in development (HSD); Essential medicines (EDM); and Essential health technologies (BCT).



Health system policies and service delivery (HSP)

WHO objective(s)

To strengthen health-system leadership and capability for effective policy-making in countries, and to enhance the planning and provision of health services that are of good technical quality, responsive to users, contribute to improved equity through greater coverage, and make better use of available resources.

Indicator(s) and achievement

- *Number of countries that have adopted new governance approaches to health system issues.* At least 70 countries have adopted new governance approaches with support from headquarters, regional and country offices.
- *Number of countries implementing strategies and organizational approaches aimed at strengthening the delivery of health services in order to ensure good technical quality, responsiveness to users and equity while making better use of available resources.* At least 50 countries have made specific efforts to strengthen health service delivery.

Main achievements

- WHO has worked with senior government officials in all regions in shaping overall sector policies, strategies and reforms. This has resulted in an increase in the number of countries where there is evidence of upstream involvement.
- WHO has significantly influenced the way in which health systems strengthening is financed by external agencies, specifically through the establishment of the Global Alliance for Vaccines and Immunization Health Systems Strengthening window. During the biennium, 40 proposals were prepared with input from WHO, and about US$420 million was made available to countries from this source.
- WHO also organized a key global meeting to help the Global Fund to Fight AIDS, Tuberculosis and Malaria reach consensus on how it should support health systems strengthening.
- WHO's work on patient safety expanded rapidly during the biennium. By the end, 72 countries were involved in the first Global Patient Safety Challenge.
- In all regions, WHO has been able to respond to a wide range of requests for support in improving the quality of service delivery, through better district planning, definition of service packages, and tools to assess performance.
- WHO has developed a framework for guiding work on health systems strengthening, namely "everybody's business", which has helped provide a focus for work at country level.

- Health systems strengthening has been more closely linked to, and integrated in, work on specific programmes and is seen as a means of producing better health outcomes.

Achievement of Organization-wide expected results

Guidance prepared and technical support provided to improve country capacity in national and local health-sector policy-making, regulation, strategic planning, implementation of reforms, and inter-institutional coordination

Indicator	Baseline	Target	Achievement
Proportion of low-income countries in which WHO has played a key role through collaborating directly in redesigning health-sector policy	Estimated number of countries having received direct policy support in 2004–2005	10 countries having received support for health-system policy-making	WHO has played a key role in providing support to over 70 countries. In some regions this constitutes about 80% of middle- and low-income countries
Number of low-income countries engaged in implementing equity tools and methods at national and/or subnational levels	Number of countries engaged in conducting subnational analyses	Double the number of countries conducting subnational analyses	A baseline was not established for this activity. Therefore, the achievement value cannot be ascertained in relation to the indicator target. However, it is known that at least 50 low-income countries made use of equity tools and methods
Proportion of low-income countries where WHO has conducted capacity-building exercises to develop methods and tools to improve equity in health	Less than 10% of eligible countries	25% of eligible countries	A baseline was not established for this activity. Therefore, the achievement value cannot be ascertained in relation to the indicator target. However, WHO has conducted capacity-building exercises in many eligible, low-income countries in the African Region, the Region of the Americas, and the European, South-East Asia and Western Pacific Regions

Partly achieved. Regional and country reports provide examples of achievements, such as coordination of the major health sector support programme in Cambodia and Nepal, designing reform strategies in the Dominican Republic, and restructuring the Ministry of Health and securing donor support in the Democratic Republic of the Congo. Equity remains a key concern in all these activities and is promoted through a range of complementary approaches. The beginning of a virtuous circle is becoming evident: as demand for more upstream policy assistance from WHO increases, the Global Alliance on Vaccines and Immunization and other donors provide links to additional funding, while a closer collaboration with the World Bank and various partners, coupled with greater policy coherence, leads to more harmonious working relationships at country level and more successful outcomes. This, in turn increases demand. At present capacity to respond at all levels of the Organization remains limited, but the growing relevance of health systems policy and service delivery is beginning to create its own pressure to scale up.

Organized approach developed for WHO's collaboration in health-sector reviews in countries, including an Internet-based mechanism for continuous provision of health-systems policy support; number of new, evidenced, knowledge-based policy briefs increased; strategies formulated for capacity building in health policy

Indicator	Baseline	Target	Achievement
Number of countries using Internet briefs effectively for policy dialogue	Nil	20 countries	80 countries and territories
Number of WHO country-office staff trained by virtual and direct methods in strengthening of health systems	All country offices in the African Region (46)	60 country offices	The exact number of country offices where staff have been trained could not be ascertained. However, it is know that the Global Alliance for Vaccines and Immunization provided the impetus for all WHO country offices in the African Region to conduct subregional workshops. In other regions, most country offices have received health systems training
Number of countries in which WHO, at national, regional or global level, has launched one development training activity for nationals on health systems	5 countries	15 countries	38 countries

Fully achieved. The Internet and related technology have been used by many countries as a means of exchanging information and gaining access to information on best practice, for example, the Health Systems Strengthening in Latin America and the Caribbean web site[1] and the web site of the European Observatory on Health Systems and Policies. These web-based systems are used in parallel with the more traditional direct training programmes for both country offices and national staff. Demand for WHO support has increased as access to technology expands in developing countries. The experience of the observatories indicates a need to sustain the quality of output and ensure that materials supplied through the Internet are used to fuel in-country policy dialogue.

Guidance and technical support provided on improved alignment of population-based public health policies and health service policies

Indicator	Baseline	Target	Achievement
Extent of review of best practice for preparation of advice and guidance on integrating public health in health services, and on engaging public-health and management networks	Existing guidance on integrating public health in health services and on new approaches to management development	Engagement of 10 international public-health and management associations; new approaches to training in public health and management in use in 5 leading public-health management schools	The exact number of international public health and management associations involved and number of leading public health management schools where new approaches to training are in use could not be ascertained

Insufficient evidence. Although achievement values for this indicator could not be ascertained, a range of activities has taken place from the integration of public health functions in service delivery to creating an advanced management framework. Through its work both at headquarters and in the regions, WHO's methods have been adopted by public health associations and management schools as envisaged. As a result, there has been a recognition that capacity building involves improving work-

[1] Accessible online at http://www.lachealthsys.org.

ing environments and creating incentives and requires good organization and proper training, as well as awareness raising. More work is needed to build bridges between public health authorities, technical programmes and those concerned with the delivery of primary health care.

Evidenced, knowledge-based guidance and technical support provided to countries for strengthening delivery of health services centred on quality, equity and efficiency

Indicator	Baseline	Target	Achievement
Number of WHO regions in which the renewed framework for health systems based on the principles of primary health care has been adapted, and support to countries initiated	1 region	3 regions	All 6 regions
Number of pilot experiences on strengthened management development	5 countries	10 Millennium Development Goal target countries	18 countries
Number of low-income countries where bottlenecks in access to care and treatment and delivery of services have been identified	Framework for studying bottlenecks in access to care and treatment using country case studies	Application of framework to 7 interested countries	43 countries

Fully achieved. The bottlenecks that have been identified are common to many countries and have been taken into consideration in the development of WHO's framework for action, known as "everybody's business". An expanding portfolio on patient safety, led from headquarters, now involves all regions and a growing number of countries and there is a growing recognition that patient safety is a matter of concern for both developed and developing countries. The emergence of the Alliance's Health Systems Strengthening window has provided the impetus for analysing constraints. But finding a way of expanding small-scale pilot initiatives remains a challenge.

Guidance and direct technical support provided to countries on effective integration of health services with disease-specific programmes

Indicator	Baseline	Target	Achievement
Adequacy of guidelines, norms and tools for improved articulation between disease-specific programmes and health services	Existing strategies for articulation between disease-specific programmes and health services	Acceptance by WHO's governing bodies of a framework for the effective integration of health services and disease-specific programmes; use of that framework in at least 7 countries	A single integrating framework was not developed and submitted to the governing bodies for approval as originally envisaged

Insufficient evidence. A wide range of guidelines, norms and tools has been developed for use in health systems and there is strong demand for WHO guidance on management matters and the integration of services. However, no single integrating framework, as originally envisaged at the planning stage was presented for the approval of the governing bodies. It is recognized that better coordination to avoid duplication of effort is needed both within WHO and between WHO and other agencies working in health service management.

Lessons learnt and actions required to improve performance

Lessons learnt:

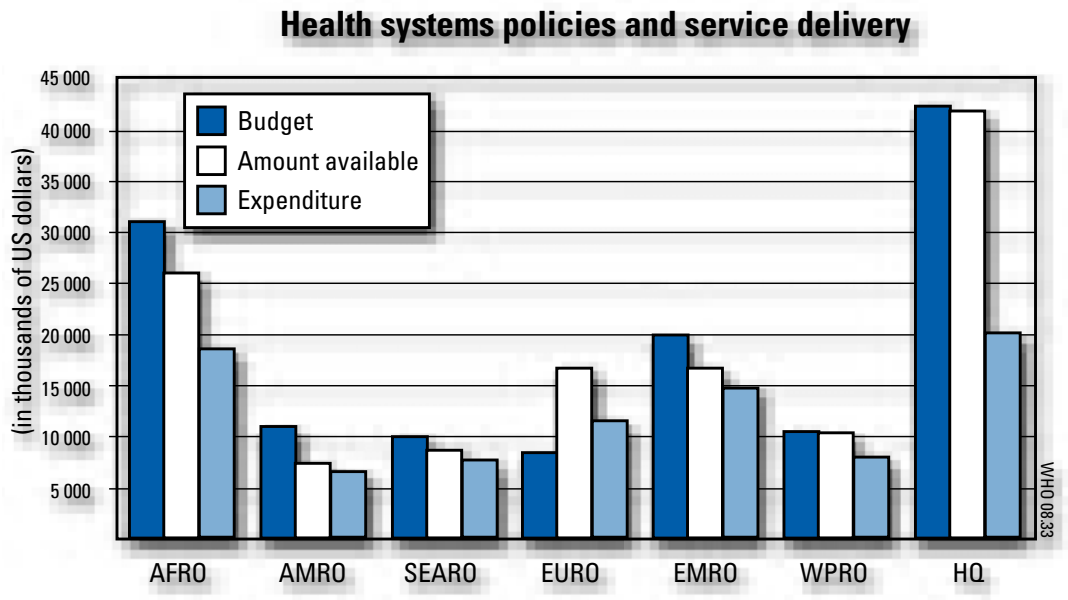
- The strengthening of countries' capacities in health policy and strategy development should be given priority by those in leadership roles and involved in governance. This is an area where efforts need to be intensified both at regional and headquarters level.
- Lessons learnt from implementing tools for assessing performance, integration and quality will be useful in revitalizing primary health care.
- The regulatory function of the state is an essential component of governance and steering. However, reviewing legal frameworks has been somewhat neglected. In particular, attention should be paid to countries that are emerging from conflict and to those undergoing chronic crises. Linkages between Health Action in Crisis and health systems strengthening interventions should be enhanced.
- WHO's limited capacity to respond to requests for support in the domain of health system policies and service delivery constrains its effectiveness.
- The achievements recorded in countries where different kinds of support have been provided offer only a limited insight into their effectiveness.

Required actions:

- To exercise governance and stewardship roles in a way that responds to countries' demands.
- To cooperate more closely in the development of tools and guidance within WHO and between WHO and other agencies, for example for resource planning.
- To define more clearly the intended outcomes of support provided by WHO in order to demonstrate its impact on countries.

FINANCIAL IMPLEMENTATION

Health systems policies and service delivery												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	7 358	23 468	30 826	10 305	15 608	25 914	84.1%	10 177	8 224	18 401	71.0%	59.7%
AMRO	2 849	7 907	10 756	5 686	1 680	7 366	68.5%	5 656	934	6 590	89.5%	61.3%
SEARO	5 791	4 087	9 878	6 974	1 679	8 653	87.6%	6 973	656	7 629	88.2%	77.2%
EURO	2 854	5 376	8 230	3 508	13 137	16 645	202.2%	3 508	7 964	11 472	68.9%	139.4%
EMRO	12 680	6 976	19 656	13 056	3 512	16 568	84.3%	13 056	1 519	14 575	88.0%	74.2%
WPRO	5 392	4 865	10 257	4 992	5 256	10 248	99.9%	4 992	2 826	7 818	76.3%	76.2%
Sub-total Regions	**36 924**	**52 679**	**89 603**	**44 520**	**40 872**	**85 392**	**95.3%**	**44 362**	**22 123**	**66 485**	**77.9%**	**74.2%**
HQ	6 378	35 686	42 064	6 511	35 300	41 811	99.4%	6 507	13 441	19 948	47.7%	47.4%
Total	**43 302**	**88 365**	**131 667**	**51 031**	**76 172**	**127 203**	**96.6%**	**50 869**	**35 564**	**86 433**	**67.9%**	**65.6%**



* *Amount available figures are not represented as such in the Financial Report and Audited Financial Statements, but include elements of both income received during 2006-2007 and amounts carried forward from the opening fund balances at 1 January 2006.*

HEALTH FINANCING AND SOCIAL PROTECTION (HFS)

WHO Objective(s)

To formulate health-financing strategies that ensure universal coverage and are based on principles of equity, efficiency and social protection, and on the best available information and knowledge; to develop capacity to obtain key information and use it to improve health financing and organizational arrangements as part of national policy.

Indicator(s) and achievement

- *Number of Member States that incorporate in their health-financing strategies the principles of equity, efficiency and social protection, and also actively search for the best available information and knowledge.* WHO collaborated with more than 60 Member States on the development of financing and social protection policies, based on the principles of equity and efficiency. The aim was to devise health financing and social protection policies and strategies that would provide universal coverage, and to obtain and incorporate the best available information into this work. Further impetus and direction was given to the work by resolution WHA58.33 on Sustainable health financing, universal coverage and social health insurance, previous Health Assembly resolutions on contracting policy, regional financing strategies and policies, and other regional policy documents. In over 50 countries, WHO helped to improve their capacity to produce key information for the development of this policy, including health expenditure flows, the extent of financial catastrophe and impoverishment linked to out-of-pocket payments for health and other forms of exclusion, and the cost effectiveness of health interventions and activities. Information on country experiences of different ways of strengthening revenue collection, fund pooling, purchasing, strategic contracting, and other forms of social protection was collated, analysed and disseminated in many forms, including in technical missions and through documents such as Technical briefs for policy makers, Policy highlights, and discussion papers, while each region engaged in at least one multi-country information sharing exercise.

Main achievements for the area of work

- Increased recognition by Member States of the importance of developing or maintaining systems of health financing and social protection has been reflected in a number of policy and strategy documents approved by the governing bodies, in which the vision and mandate for the Organization's work is described.
- Through policy discussions, analytical work and capacity building, WHO has been able to promote and facilitate national level policy processes that are consistent with the goal of universal coverage and the other health finance and social protection objectives elucidated in the governing body documents.
- WHO has also made a substantial contribution to the collation, analysis and dissemination of key information needed by decision makers, linked partly to the data but also to shared experiences of effective actions and best practices.
- WHO staff working in this area are collaborating more extensively with internal and external partners who have a need for or expertise in all forms of health financing and social protection. Depending on need, collaboration takes place at country, regional and global levels.

Achievement of Organization-wide expected results

Policy options, guidelines and recommendations on health financing and social protection developed consistent with WHO's commitment to universal coverage, and used in countries

Indicator	Baseline	Target	Achievement
Availability of policy options and guidelines on key dimensions of financing and social protection policy, priority-setting, and ways of reducing the risks associated with out-of-pocket payments	14 policy-issue papers on financing and social-protection policy, contracting, priority-setting and use of cost-effectiveness analysis, cost of expanding interventions	Additional 8 policy-issue papers on financing and social-protection policy, contracting, priority-setting, use of cost-effectiveness analysis, financial cost of expanding interventions, non-health benefits of interventions	16 additional policy-issue papers were produced to help share information on country experiences and best practices. This included a publication on policy options for social protection policy, priority-setting, and ways of reducing the risks associated with out-of-pocket payments for mother, newborn and child populations
Extent of the use of these policy options, guidelines and recommendations in countries to improve the social protection, efficiency and/or equity of their financing systems	Use of policy papers in 10 countries, including by established commissions on macroeconomics and health and in sector-wide approaches in selected countries	Use of policy options, guidelines and recommendations in 17 countries, including by established commissions on macroeconomics and health and in sector-wide approaches in selected countries	More than 60 countries across all regions requested and received technical support from WHO

Fully achieved. Regional financing frameworks or strategies were developed and approved in two regions. In a third, financing and social protection strategies were incorporated into the overall regional health agenda policy document. This increases the availability of policy documents developed in regions and through the World Health Assembly. While established goals and targets have been met, there is still a great demand from Member States for new and continuing support. Recent governing body resolutions and the endorsement of strategies by the Executive Board, World Health Assembly and in several regions have provided direction and momentum. Key health financing and social protection problems facing countries at all levels of development are now clearly understood, and a vision of how they can be analysed and addressed has been developed and is widely accepted by Member States. Building and maintaining partnerships across different levels of the Organization, between WHO priority programmes, and with outside partners has also proved valuable. During the past two years, countries have increasingly recognized the need to further develop their health financing systems and improve or maintain levels of social health protection. Meeting these demands will be a challenge in the next biennium.

Information on best practices with respect to financing and social-protection policy, priority-setting and generation of key information provided to countries, and its use supported

Indicator	Baseline	Target	Achievement
Availability of policy briefs on key questions in health financing, social protection and priority-setting in a form that is readily accessible to policy-makers	8 policy briefs available; no existing comparative case studies on priority-setting and insurance reimbursement	14 policy briefs available; comparative case studies on priority-setting and insurance-reimbursement decisions	35 policy documents and briefings produced
Extent of use of policy briefs in national policy debate and to guide policy implementation	Used in 10 countries, including in policy debates on financial-risk pooling	Used in 17 countries, including in policy debates on financial-risk pooling and social protection	More than 30 countries were supported in the area of financial risk pooling and social protection

Fully achieved. The sharing of experiences related to financing and social protection approaches and policies and best practices is widely requested by Member States. The information contained in the various policy documents often contributes usefully to the technical support requested by Member States. WHO staff working on health financing and social protection maintain a high level of technical expertise and continue to engage in a dialogue with Member States and partners within and outside WHO.

Key tools, information and knowledge to guide policy framing and implementation validated and their use supported

Indicator	Baseline	Target	Achievement
Availability of practical guides on national health accounts and resource tracking; availability of tools to describe and analyse arrangements for collection, pooling and purchasing, and associated issues of system structure, to help in setting priorities for available and new resources and to expand key interventions, to determine the extent and nature of financial risks and catastrophic expenditures, and to assess options to reduce financial risks and expand social protection	First version of tools on financial implications of financing arrangements, contracting, country contextualization for priority-setting, cost of expanding interventions; no existing tool for estimating non-health benefits of interventions	Improved tools on resource tracking, impact of financing arrangements and out-of-pocket payments, contracting, country contextualization for priority-setting, cost of expanding interventions; new tool for estimating non-health benefits of interventions	Practical manuals have been produced for tracking health expenditures and budgets, including for specific diseases. Methods for estimating the impact of out-of- pocket payments on financial catastrophe and impoverishment have been disseminated. Guidelines have been drawn up for a policy dialogue on social protection in health. An approach to strategic contracting, as well as tools for estimating the cost of scaling up health interventions, including for specific diseases such as malaria, and programmes, for example on child health, have been developed. A tool to identify the cost effectiveness of interventions is also now available. A tool for measuring the financial sustainability of different forms of health insurance has been disseminated. Methods for identifying the economic consequences of diseases have also been devised

Indicator	Baseline	Target	Achievement
Extent of use of tools, guides and knowledge in countries	Use of tools for resource tracking, calculating financial risks to households, financing and contracting in 20 countries; country contextualization for priority-setting undertaken in 4 countries; integrated costing tool used in 4 countries; database available on cost effectiveness of 300 interventions; no existing estimates of non-health benefits; annual reporting of summary ratios of health expenditures	Use of tools for resource tracking, calculating financial risks to households, financing and contracting in 30 countries; country contextualization for priority-setting undertaken in 12 countries; integrated costing tool used in 12 countries; database available on the cost effectiveness of 400 interventions; estimates of non-health benefits available for 6 countries; annual reporting of summary ratios of health expenditures	Use of tools was supported in over 50 countries through country-specific capacity building and technical support. The database on cost effectiveness now includes over 700 interventions. Health expenditures were updated annually for all Member States, with satellite accounts receiving support in the Region of the Americas. Countries were also given help to estimate the cost of scaling up particular interventions, especially those linked to the Millennium Development Goals

Fully achieved. Tools, guidelines and methods in all the planned areas of health financing and social protection have been developed, and important data required for informed decision making, including on health expenditures, has been collated and reported. The various processes have benefited from a clear understanding of Member States' needs acquired through continuing discussions, increased collaboration within the Organization as a whole, and more multilateral and bilateral partnerships for technical aspects and financing. Some regions continue to be constrained by a lack of skills in financing and health economics, exacerbated by a growing number of requests for assistance from Member States.

Strengthened country capacity to obtain information and use it to formulate plans and policies and guide interventions for improving systems of health financing and social protection

Indicator	Baseline	Target	Achievement
Number of countries or regions benefiting from training programmes, conducted in collaboration with partners, on the use of the tools and guidelines; analysis of the results, followed by policy dialogue	Training courses on national health accounts, priority-setting, costing and catastrophic expenditures in 2 regions per year; training courses on implications of health financing and contracting in 5 countries	New training courses on national health accounts, priority-setting, costing, risk protection and catastrophic expenditures in 2 regions per year; training courses on implications of health financing and contracting in 8 countries	9 multi-country training courses in health financing policy were held. Further training courses were conducted in social health insurance, health systems development, including financing, social protection in health policies, and cost-effectiveness in relation to infectious diseases

Indicator	Baseline	Target	Achievement
Existence of working networks of technical experts established for priority-setting, costing and cost-effectiveness	2 working networks on national health accounts	At least 1 working network on costing, cost-effectiveness, and financing policy, with participation of all regions	There are now three regional networks and one cross-regional network on health economics and financing, as well as two networks for resource tracking and cost-effectiveness analysis, respectively. At the global level, networks have been established for social health protection, health accounts and disease-specific resource tracking. There is also an active global network of WHO specialists in health financing, and another information sharing group on strategic contracting

Fully achieved. WHO's active participation in country, sub-regional, regional and international training programmes and policy debates has been continually requested by Member States and other partners. This is reflected in the increasing availability of country-level information on policy development, including health expenditures, the incidence of financial catastrophe and other forms of inequality, the cost of scaling up, and the cost effectiveness of interventions.

Lessons learnt and actions required to improve performance

Lessons learnt:

- A major constraint facing WHO is a continuing lack of funds in many countries. This prevents many Member States from scaling up health services and systems rapidly. Developing appropriate responses requires active collaboration with ministries of finance, central banks, international financial institutions and multilateral and bilateral partners.
- There is still considerable inequality in the context of social health protection. For example, heavy reliance on out-of-pocket payments to fund health care results in exclusion and severe financial hardship, while many people are not protected from the impact that poor health can have on their livelihoods. Responding to this challenge is complex especially where the funds available for health are scarce. Responses need to take into account the history and culture of countries, as well as the nature of local institutions.
- Actions in some settings are constrained by limited country-level skills in economics and financing. To achieve universal coverage more quickly it will be necessary to increase those skills, and also to foster mutual understanding between financing and health experts.
- Sharing information on effective actions for health financing and social protection among Member States has proved valuable in developing strategies for attaining universal coverage.
- The demand for technical support, analytical work and capacity building from Member States is growing and WHO must be able to respond appropriately.

Required actions:

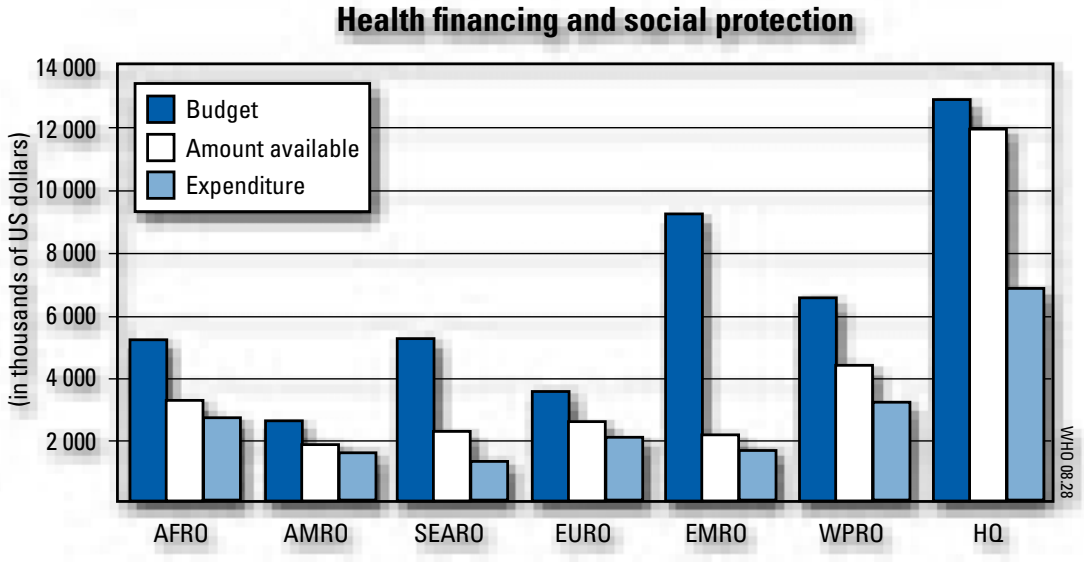
- WHO should focus on devising strategies to reduce the extent to which out-of-pocket payments are used to finance health systems where costs are high. This will improve access to promotion, prevention, treatment and rehabilitation services and protect people from the financial consequences of ill health.

- WHO will need to be flexible in order to respond to changing and growing demands from Member States and maintain a dialogue with other multilateral agencies working in the area.
- In regions and countries that lack skills in health financing and social protection, WHO must work with Member States to build capacity, possibly by supporting regional networks.
- WHO staffing levels need to be aligned with the anticipated workload, and its ability to serve the Member States should be enhanced through the recruitment of high-quality, respected individuals.
- The way in which key messages on health financing and social protection are communicated to Member States and the global community needs to be improved.

[1] All numbers reported comprise activities taken by regional offices by themselves and through collaboration between headquarters and the regional offices..
[2] All numbers reported include activities undertaken by regional offices either independently or in collaboration with headquarters.

Financial implementation

Health financing and social protection												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	755	4 419	5 174	1 786	1 445	3 231	62.4%	1 786	886	2 672	82.7%	51.6%
AMRO	1 471	1 088	2 559	1 242	572	1 814	70.9%	1 239	288	1 527	84.2%	59.7%
SEARO	3 963	1 213	5 176	1 090	1 134	2 224	43.0%	1 090	164	1 254	56.4%	24.2%
EURO	1 200	2 300	3 500	1 411	1 119	2 530	72.3%	1 411	630	2 041	80.7%	58.3%
EMRO	1 185	8 015	9 200	586	1 515	2 102	22.8%	585	1 007	1 592	75.8%	17.3%
WPRO	1 392	5 108	6 500	1 688	2 667	4 355	67.0%	1 688	1 489	3 177	72.9%	48.9%
Sub-total Regions	**9 966**	**22 143**	**32 109**	**7 802**	**8 453**	**16 255**	**50.6%**	**7 799**	**4 464**	**12 263**	**75.4%**	**38.2%**
HQ	6 179	6 679	12 858	4 637	7 304	11 941	92.9%	4 637	2 176	6 813	57.1%	53.0%
Total	**16 145**	**28 822**	**44 967**	**12 439**	**15 757**	**28 196**	**62.7%**	**12 436**	**6 640**	**19 076**	**67.7%**	**42.4%**



* *Amount available figures are not represented as such in the Financial Report and Audited Financial Statements, but include elements of both income received during 2006-2007 and amounts carried forward from the opening fund balances at 1 January 2006.*

Health information, evidence and research policy (IER)

WHO objective(s)

To improve the availability, quality and use of health information at country level; to strengthen the evidence base at regional and global levels in order to monitor and reduce inequalities in health; to develop health-research systems, to build research capacity, and to use research findings to strengthen national health systems.

Indicator(s) and achievement

- *Production and use of accurate and timely health information in countries.* A substantial number of countries assessed their health information systems and began to address weaknesses in a systematic manner. Better data became available on the coverage of interventions through surveys and improved health facility reporting in some regions. The use of comprehensive data at country level, for example through burden of disease studies, to assess progress and performance of the health system increased. However, the availability and quality of statistics on causes of death and health systems in high mortality countries continued to be limited.
- *Ability of countries to report on the key health-related Millennium Development Goals.* Improvements were made in monitoring child mortality and coverage of some interventions through more frequent health surveys and the strengthening of clinical reporting systems or combinations thereof. The ability to report on progress made in reaching Millennium Development Goal 5 on maternal mortality continued to be limited in high-mortality countries, while time lags hampered reporting on Goal 4 on child mortality. There was some improvement in the monitoring of progress towards Goal 6, including prevalence of HIV/AIDS and level of intervention coverage, the treatment success rate for tuberculosis and level of intervention coverage for malaria.
- *Level of resources mobilized compared to the funding gap.* There is no evidence of a reduction in the funding gap for health research.
- *Equity of access to knowledge and health information.* All the regions and headquarters maintained their databases on health statistics despite high levels of use, and continued to publish related annual health statistical materials. Activities to ensure that information and evidence are used in decision making were stepped up in a growing number of countries, for example, through the evidence-informed policy network known as EVIPNET.

Main achievements

- The availability of publications and web sites providing health statistics in regions and at headquarters, such as World Health Statistics 2007, encourages a high level of web usage and an effort is made to ensure that the information is widely accessible.
- Progress has been made in efforts at country level to strengthen health systems research and health information systems.
- Health situations and health trends, including the global burden of disease, mortality and causes of death, in the African Region and the Region of the Americas, as well as worldwide, have been analysed.
- Support has been provided for implementation of the following standards: the International Classification of Diseases, the International Classification of Functioning, Health and Disability and health service delivery standards, as well as for revision of the International Classification of Diseases.

Achievement of Organization-wide expected results

Strengthened and reformed country health-information systems that provide and use quality and timely information for local health problems and programmes and for monitoring of major international goals

Indicator	Baseline	Target	Achievement
Number of countries with adequate health-information systems in line with international standards as defined within the Health Metrics Network	Number of countries currently meeting the standard	25 additional countries making significant progress towards achieving the standard for a sound health-information system	More than 60 countries made significant progress through comprehensive assessment of their systems. More than 25 countries made significant progress in reporting more detailed health data for policy support
Number of countries adapting or using specific materials and tools, such as the International statistical classification of diseases and related health problems and the International classification of functioning, disability and health, and reviews of health status and health-systems metrics	Number of countries currently using specific materials and tools	At least 10 additional countries using specific materials and tools	Over 10 countries started to use or improve their use of key WHO guidelines and tools for health information

Fully achieved. Many countries made considerable progress in strengthening data collection through a comprehensive assessment of their health information systems based on the Health Metrics Network framework, often with the help of Network grants. Strategies for strengthening vital and health statistics were developed and implemented in the Region of the Americas and the South-East Asia Region. Many countries improved certain aspects of their health information systems, using WHO guidelines and tools, which led to better reporting and use of information. For instance, more than 25 countries made progress in reporting more detailed health data and in developing online health indicator databases to support policy making, especially in the Region of the Americas and the European Region, and in the African Region in conducting service delivery assessments. There has been limited progress in implementing the International Classification of Diseases, but efforts are being made to introduce partial civil registration systems in at least five countries, to accelerate the process in the Region of the Americas and the South-East Asia Region, and to improve reporting on morbidity in the European Region. More than 10 countries have started using service availability mapping tools to obtain information on strengthening health systems, especially in the African Region. The main areas in which progress has been slow include: causes of death in countries with no vital registration systems and limited use of International Classification of Diseases coding, and health systems information in countries with weak health systems. These areas require major investment by WHO, international partners and countries.

Better knowledge and evidence for health decision-making, by consolidation and publication of existing evidence and facilitation of knowledge generation in priority areas

Indicator	Baseline	Target	Achievement
Existence of a WHO database of core health indicators with metadata, focusing on health-related Millennium Development Goals	Partly harmonized databases in regional offices and headquarters	Harmonized and consistent high-quality databases with metadata available and well used	Headquarters and regional offices maintain comprehensive databases of comparable country health statistics, which are used extensively; country profiles and databases updated in all offices
Number of areas in which WHO's work has generated new evidence to redirect health programmes or reinforce existing priorities	Number of key areas in which WHO needs to generate new evidence through generation or consolidation of evidence	All priority areas addressed through, for example, analytical reports or comparative analyses	Global and regional evidence generated through analysis and synthesis, and support provided for new data collection on key topics, such as death registration, ageing and health and health systems monitoring

Fully achieved. Progress has been made in increasing access to comparable country health statistics in the regions and at headquarters. All offices now use a set of core health statistics for reporting and, increasingly, describe metadata. Information on countries is available in annual publications, such as *World Health Statistics* 2007, and in regional office brochures on health statistics. Further work on improving access to health statistics is needed to achieve the same level of dissemination as, for instance, in the European Region, where partners have been mobilized to develop an improved web portal. WHO also provides health data to the United Nations harmonized monitoring systems on the Millennium Development Goals. During 2006–2007, WHO generated new evidence for advocacy, policy changes and enhanced programme implementation on a variety of topics through the synthesis of existing data and involvement in new data collection from multicountry studies. These include: causes of death, for example, a Lancet series and guidelines on use of verbal autopsy to ascertain cause of death through interviews; ageing and health; comprehensive health information obtained through work on the global burden of disease; and health systems monitoring, especially of service delivery. Major cross-cutting analyses were published on health situations and trends by the Regional Offices for Africa and the Americas. However, the investment made by countries and international partners in well-coordinated efforts to collect and analyse data on priority health topics remains limited. For instance, the introduction of death registration needs major long-term investment.

Strengthened national health research for health-systems development, within the context of regional and international research and engagement of civil society; WHO programmes and initiatives in research for health-systems development and for access to, and use of, knowledge effectively developed and implemented on the basis of strategic priorities

Indicator	Baseline	Target	Achievement
Number of targeted countries and collaborators using or adapting WHO guidelines and tools for analysis and strengthening capacity of national health-research systems	10 to 15 developing countries having updated their strategies for strengthening national health-research systems using WHO guidelines and tools	10 to 25 targeted developing countries updating health-research strategies and applying WHO tools	15 to 20 countries are applying and piloting WHO guidelines and tools for assessing performance of health research systems and strategies

Availability of a core set of health-system research priorities for WHO	Draft framework of priorities available	Final list of priorities	Work is in progress in several countries to determine priorities and assess methodologies
Effectiveness of WHO global programme in research for health-systems development	Draft plan for programme available	Programme launched and implemented in all regions	The programme has been launched by the Alliance for Health Policy and Systems Research with participating countries in all WHO regions
Existence of initiative to build capacity in research consolidation in countries	No coordinated initiative in place	Initiative implemented in selected countries	Consolidation of research through the synthesis of evidence to inform policy development has been carried out in 25 countries in the African Region, the Region of the Americas and the Western Pacific Region

Partly achieved. Regional offices and headquarters have made progress in implementing one of the key recommendations of the Ministerial Summit on Health Research, held in Mexico City in 2004, namely the adoption of a "bottom-up" approach based on commonality of needs for identifying mutual problems. However, implementation has been hampered by limited capacity to analyse initiatives in country and regional offices. Several countries in the African Region are continuing to adapt and test indicators for assessing national health research systems using tools and methodologies developed by the Health Research System Analysis initiative.

WHO-led networks and partnerships established that improve international cooperation for health research, including a strong and effective Advisory Committee on Health Research at global and regional levels, WHO collaborating centres and expert advisory panels

Indicator	Baseline	Target	Achievement
Functionality of mechanisms such as the Partners' Forum to promote strong partnerships and synergy between key organizations at global level	Minimal coordination of independent activities	Effective mechanisms for partnerships and coordination of activities between key organizations	Functional mechanism involving multiple partners (the Council on Health Research for Development, the Global Forum for Health Research, UNESCO, the World Bank and the Government of Mali)
Coverage of the network of national task forces on health research and health systems, that work in close cooperation with WHO global, regional and country counterparts	10 to 15 national task forces on health-research systems established in targeted countries	10 to 20 additional national task forces on health research and health systems developed in targeted countries	Increased network coverage in 25 countries in 3 WHO regions where national task forces have been established to strengthen linkages between research and health policy development
Extent of networking between WHO collaborating centres in high priority areas	Several networks in high-priority areas	Larger number of networks in high-priority areas	Several new networks formed and others strengthened, for example, for environmental health and health promotion
Effectiveness and impact of WHO's policy for collaborating centres	Draft of new policy agreed by all regions	New policy fully implemented	New policy implemented
Number of initiatives commissioned by global Advisory Committee on Health Research	No significant initiatives developed or implemented	2–3 initiatives implemented in priority areas	All planned initiatives for better use of evidence, ethical reviews and clinical trial registration implemented

Fully achieved. Functional mechanisms to promote strong partnerships and synergy between key organizations at global level have been established. The Council on Health Research for Development, the Global Forum for Health Research, UNESCO, the World Bank and the Government of Mali have been involved in the organization of the 2008 Global Ministerial Forum on Research for Health, to be held in Bamako from 17–20 November 2008, with the key objective of providing a platform for dialogue to the major health research funding bodies. The regional offices and headquarters have also been closely involved through the organization of preparatory meetings in all regions and the establishment of national teams to strengthen linkages between research and policy in three regions. A common desire for a better use of evidence in policy development led to agreement on the need for a high-level forum to maintain visibility and ensure continued support. However, regional specificities and needs must be taken into account even though they may be difficult to reconcile with common goals, especially when capacity is limited as in the case of collaborating centres. In addition, 25 countries in the African, South-East Asia and Western Pacific Regions have established national task forces to strengthen linkages between researchers and policy makers as part of WHO's evidence-informed policy networks initiative. These teams are working closely with regional and country offices and are receiving strong support from their national governments. New networks of collaborating centres have been established and the new policy implemented in stages.

Guidelines and standards determined that ensure ethical conduct of health research and best practices disseminated within WHO

Indicator	Baseline	Target	Achievement
Level of harmonization of ethics review procedures at headquarters and regional offices	Standard ethics review procedures established at headquarters	Ethics review procedures harmonized at headquarters and in the regions	An improved level of harmonization has been achieved through new mechanisms for strengthening and harmonizing ethical review capacity in regional offices

Partly achieved. Regional offices and headquarters, working together, have identified specific activities with the potential for overcoming problems, for example: establishing ethical review committees in regional offices; publishing an ethical review case book; organizing ethical review workshops in regional offices and encouraging participation of regional office staff in headquarters' ethical review workshops; and developing online ethical review training courses. The Regional Office for South-East Asia has worked closely with headquarters in running courses to improve its own ethical review capacity and that of some member countries. Discussions have also begun on the possibility of an interregional meeting to harmonize ethical review processes and standards. While there is unanimous agreement that ethical review is an important component of research, progress is hampered by limited capacity in the regional offices. More resources and training are therefore required at regional level.

Lessons learnt and actions required to improve performance

Lessons learnt:

- It will take time and require support from WHO to satisfy increasing demand for better information and evidence through the upgrading of country health information and research systems.
- The low level of investment in information and evidence work in regional offices and headquarters, and a lack of designated staff in country offices, require careful prioritization of the agenda, which should focus on norms and standards, standardized multicountry approaches and data analysis and synthesis.

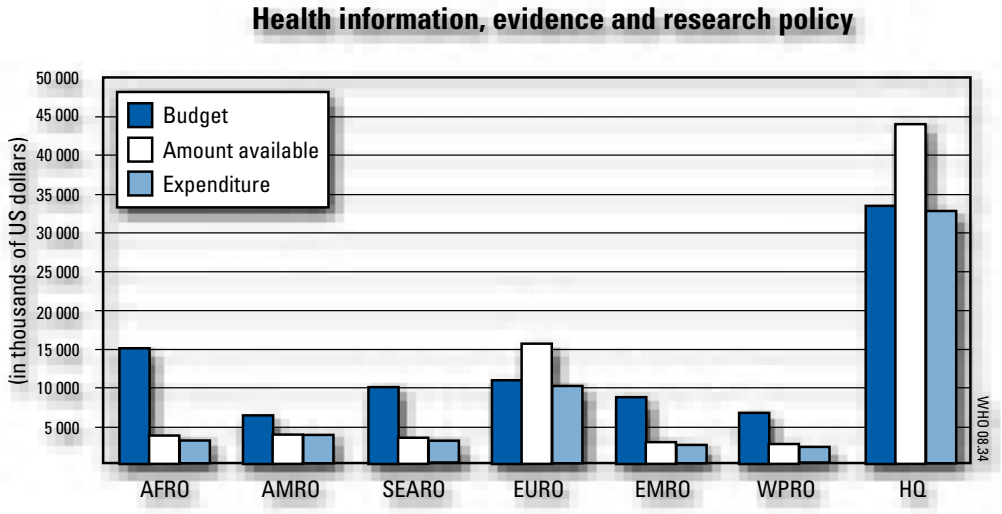
- Continuous, structured interactions with regional office counterparts are needed to facilitate the harmonization of various activities.

Required actions:

- To enlist support from partners that takes account of changes in the health landscape in countries, as well as demand for health information.
- To focus on key WHO functions, such as standards, standardized multicountry approaches for technical assistance, generation of data on neglected topics, and analysis and synthesis operations with effective communication of results.
- To harmonize and streamline data flows between different levels of the organization in a systematic manner.

FINANCIAL IMPLEMENTATION

Health information, evidence and research policy												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	864	14 040	14 904	1 213	2 560	3 773	25.3%	1 212	1 701	2 913	77.2%	19.5%
AMRO	4 310	1 934	6 244	3 582	415	3 996	64.0%	3 557	265	3 822	95.6%	61.2%
SEARO	1 648	8 327	9 975	2 840	637	3 477	34.9%	2 840	519	3 359	96.6%	33.7%
EURO	3 668	7 082	10 750	2 753	12 853	15 606	145.2%	2 753	7 311	10 064	64.5%	93.6%
EMRO	2 347	6 324	8 671	2 182	592	2 774	32.0%	2 182	264	2 446	88.2%	28.2%
WPRO	1 784	4 816	6 600	2 003	806	2 809	42.6%	2 002	528	2 530	90.1%	38.3%
Sub-total Regions	**14 621**	**42 523**	**57 144**	**14 572**	**17 862**	**32 434**	**56.8%**	**14 546**	**10 588**	**25 134**	**77.5%**	**44.0%**
HQ	6 530	26 732	33 262	6 268	37 593	43 861	131.9%	6 266	26 156	32 422	73.9%	97.5%
Total	**21 151**	**69 255**	**90 406**	**20 840**	**55 455**	**76 295**	**84.4%**	**20 812**	**36 744**	**57 556**	**75.4%**	**63.7%**



* *Amount available figures are not represented as such in the Financial Report and Audited Financial Statements, but include elements of both income received during 2006-2007 and amounts carried forward from the opening fund balances at 1 January 2006.*

Human resources for health (HRH)

WHO objective(s)

To contribute to managing effectively and creatively the interaction between the supply and demand for health workers.

Indicator(s) and achievement

- *Successful retention of an expanded health workforce in countries, reprofiled to meet health needs*. As a result of strong advocacy to mark the launch of The world health report 2006: working together for health, and the concerted efforts of many partners, more countries were made aware of the challenges involved in achieving the Millennium Development Goals with regard to human resources for health, and in delivering effective primary care services. Strategic consensus documents have been endorsed in most regions which point out the central role of human resources and the importance of retaining them in order to improve health systems performance and health indicators. Strategies that have been adopted by countries include, ensuring decent working conditions, upgrading the skills of mid-level cadres, designing new training strategies that more closely meet the needs of communities, and topping up salaries from donor funds. In some countries, there has been an increase in the ratio of health human resources to population compared to the previous biennium.
- *Strengthened national capacity for policy framing and management of the health workforce*. Most countries are reviewing their national health human resources plans and policies or are producing new ones based on the guidelines that have been drawn up for that purpose. In some regions, such as the Region of the Americas, the plans and policies are linked to regional strategies and goals. Several countries have revised and strengthened the role of human resources departments in ministries of health. Regional observatories for human resources in health have been established in the African and Eastern Mediterranean Regions, while the traditional network of observatories in the Region of the Americas has continued to grow. National observatories have also been developed in 11 countries to support and improve the process of evidence-based policy and decision making.

Main achievements

- Increased advocacy has placed the crisis in human resources for health at the top of the international agenda. *The world health report 2006: working together for health* highlighted the worldwide crisis in the health workforce, which in practical terms means there is an absolute shortage of about 4 million health workers in 57 countries, mostly in sub-Saharan Africa and Asia. The report presented an overview of potential interventions and proposed a 10-year action plan for solving the crisis. Advocacy in all regions for World Health Day 2006, which was dedicated to the health workforce, helped to increase awareness of the magnitude of the problem and the need for urgent action.
- The Global Health Workforce Alliance was launched in May 2006 with the aim of strengthening advocacy and giving international prominence to concerns about the health workforce. The Global Alliance works with other partners, including WHO, to implement effective interventions for reducing the shortage of health workers in most affected countries, and to build up a well-performing

health workforce worldwide. Other regional alliances and partnerships have been formed, such as the Asia-Pacific Action Alliance on Human Resources for Health and the newly-established Pacific human resources for health alliance, with the aim of providing a coherent and coordinated response to specific regional problems.

- Governing bodies at global and regional levels have endorsed several resolutions on workforce development: the Fifth-ninth World Health Assembly adopted a resolution on strengthening nursing and midwifery[1] and another on the rapid scaling up of the health workforce,[2] which urges Member States to accelerate their efforts to expand the workforce and in so doing reduce the global shortage of about 4 million workers. Regional Committees in the Region of the Americas and the European, South-East Asia and Western Pacific Regions have also endorsed regional resolutions on human resources for health.
- Regional strategies or Ministerial Declarations have also been endorsed in three regions: the Regional Goals for Human Resources for Health 2007-2015 in the Region of the Americas, the Islamabad Declaration on Nursing and Midwifery in the Eastern Mediterranean Region, the Dhaka Declaration in the South-East Asia Region and the regional nursing strategic plan in the Western Pacific Region. They are all examples of strong political commitment at the highest level to solving the crisis in the health workforce.
- A common framework for action is being implemented in a number of countries to provide the coherent and comprehensive approach needed for policy analysis and development. Regional and national observatories have been created to strengthen and support the process of evidence-based policy and decision making.

Achievement of Organization-wide expected results

Guidance and support provided for effective analysis, planning and management of the health workforce in countries

Indicator	Baseline	Target	Achievement
Number of countries using WHO human-resources planning and management guidelines	According to surveys to be carried out in 2005	At least 20 more countries	Owing to organizational changes the planned baseline survey was not conducted. Therefore, an achievement value cannot be established for the indicator target. Nevertheless, it is known that 73 countries used human resources planning and management guidelines to either review existing or develop new national human resources for health strategies, policies and plans
Number of countries using evidence-based tools to improve recruitment and retention of health workers	According to surveys to be carried out in 2005	At least 20 more countries	Owing to organizational changes the planned baseline survey was not conducted. Therefore, an achievement value cannot be established for the indicator target. Nevertheless, it is known that 33 countries are implementing various types of retention strategies

Insufficient evidence. WHO played a key role in an intensified advocacy campaign to increase awareness of the global crisis in health human resources. Many more countries have begun to review or draw up new national strategic health human resources plans. Some countries have given high political visibility to the subject by establishing top-level oversight mechanisms to encourage further action, such as the prime-

[1] Resolution WHA59.27.
[2] Resolution WHA59.23.

ministerial level coordinating body in Mongolia. New analysis and planning tools and instruments have been made available to countries both at global and regional level, for example the human resources for health action framework, developed in collaboration with a range of partners. In the Western Pacific Region, a regional code of practice provides guidelines on an ethical approach to the international recruitment of health workers, taking into account the potential impact of such recruitment on health services in source countries. It also seeks to safeguard the rights of recruits and professional conditions in the recruiting countries. More needs to be done to make the tools and best practices for planning and retention more accessible to countries.

Strengthened leadership, policy-making, public health, management and research capacities

Indicator	Baseline	Target	Achievement
Number of countries in which WHO actively demonstrates institutional capacity for supporting leadership	According to surveys to be carried out in 2005	At least 15 countries	Owing to organizational changes the planned baseline survey was not conducted. Therefore, an achievement value cannot be established for the indicator target. Nevertheless, it is known that 63 countries in all regions benefited from leadership and management training, or showed commitment to improving institutional capacity to strengthen leadership
Number of evidence-based products developed to support and sustain leadership in human resources for health	10 at the start of the biennium	At least 10 disseminated globally	10 products were developed and disseminated: The world health report and 5 policy briefs were published and disseminated globally
Functioning health leadership programme	At least 35 officers enrolled	At least 30 more officers enrolled	116 professionals, among them 66 senior officials from China, from 18 countries in 2 regions participated in a leadership training programme

Partly achieved. Indicator targets 2 and 3 have been met, however it was not possible to assign a value to the first one. Work began, in collaboration with headquarters, on mapping health service managers in nine countries in the African and Eastern Mediterranean Regions in order to better understand management capacity and needs at country level. The Health Leadership Service programme, led from headquarters, has been reorganized to focus on the training of practitioners in Africa, where the crisis is deepest. A new health leadership training programme for nursing has been launched in Lithuania, and the leadership and management training programme developed by the International Council of Nurses has continued to be implemented across the Eastern Mediterranean Region. Ten products were developed and disseminated: *The World Health Report* and five policy documents, a chapter on leadership and management in health for the *Oxford Textbook of Public Health*;[3] an online training programme on human resources for health policies and interventions for professionals in key posts in the Region of the Americas; an international course in human resources for health offered jointly with Brazil to participants from the Andean countries and Chile; a study on ministries of health human resources departments in the Region of the Americas; and a publication on health worker migration and policy implications in Europe. Regional publications or products on human resources for health and leadership include: two books on the health workforce published by the European Observatory on Health Systems and Policies[4] and two strategic action plans for nursing and/or midwifery development for the Pacific region. More focused research on leadership and management needs to be encouraged during the 2008–2009 biennium. The increased attention being paid to training leaders and managers is the key to advancing policies on human resources. Strategic documents and political declarations at regional and global level have also prepared the ground for the strengthening of health workforce leadership and management.

[3] Detels, Roger et al., eds. *Oxford Textbook of Public Health*, 4th edn. Oxford, Oxford University Press, 2002.

[4] Dubois, Carl-Ardy et al., eds. *Human resources for health in Europe*. Geneva, World Health Organization 2006 and Bernd, Rechel et al., eds. *The health care workforce in Europe: learning from experience*. Geneva, World Health Organization, 2006.

Strategies to reduce the outflow of health workers promoted

Indicator	Baseline	Target	Achievement
Number of countries with policies and strategies designed to reduce the outflow of health workers	According to surveys to be carried out in 2005	At least 25 countries	Owing to organizational changes the planned baseline survey was not conducted. Therefore, an achievement value cannot be established for the indicator target. Nevertheless, it is known that 24 countries and areas in 2 regions have specific strategies to reduce outflows of health workers

Insufficient evidence. The international migration of health workers has continued to act as a spur to efforts at global level. For example, WHO and the OECD have been working together to increase the amount of data and information available on patterns of health workforce migration. In collaboration with the Global Health Workforce Alliance and other partners, WHO has continued to develop instruments for ethical recruitment of health workers, as mandated by resolution WHA57.19. An analysis of current codes of practice for international recruitment is under way, and a framework for a global code of practice is being prepared. More needs to be done to engage countries in consultations on the regional specificities of migration. The Fifty-seventh session of the Regional Committee for Europe adopted a resolution on health workforce policies in the European Region to address the impact of health workforce migration.[5] Some countries in the Region of the Americas are negotiating agreements with receiving countries to mitigate the impact of the outflow of health workers. Three countries in the African Region have reported specific incentive schemes for retaining health workers, while three other countries have implemented Memoranda of Agreement on the recruitment of health workers. In the Western Pacific Region, the Pacific Code of Practice for Recruitment of Health Workers and the compendium document have been endorsed by Ministers of Health for the Pacific Island Countries, representing 18 countries and areas. For internal migration, global guidelines and recommendations on task shifting as a strategy for the rational redistribution of tasks among health-care teams have been produced to expand access to health services.

Practical guidance and tools to ensure quality of education and training and its relevance to needs available to countries and used in targeted countries

Indicator	Baseline	Target	Achievement
Number of countries in which WHO supports assessment of education of health professionals, including evaluation of training programmes and review of curricula	According to surveys to be carried out in 2005	20 more countries	Owing to organizational changes the planned baseline survey was not conducted. Therefore, an achievement value cannot be established for the indicator target. Nevertheless, it is known that 35 countries in 4 regions evaluated their education programmes or revised the curricula for medical, nursing and public health education
Number of targeted countries in which tools, guidelines and methods for improving quality and standards of training and education of health professionals are used	According to surveys to be carried out in 2005	50 countries	Owing to organizational changes the planned baseline survey was not conducted. Therefore, an achievement value cannot be established for the indicator target. Nevertheless, it is known that 58 countries used tools and other methods for improving the quality of education and training for health professionals

[5] Resolution EUR/RC57/R1.

Insufficient evidence. The assessment and improvement of educational quality is a well-established process. The African Region, the Region of the Americas and the European and Western Pacific Regions have assessed education and training programmes in many countries and have implemented tools for improving the quality of education for health professionals, including revision of curricula and innovative training approaches. WHO collaborating centres in the regions have supported these efforts. The Western Pacific Region distance learning network, the Pacific Open Learning Health Net, has developed 27 courses over the biennium.

Strengthened institutions and processes that will increase capacity for research on human resources for health in countries

Indicator	Baseline	Target	Achievement
Number of institutions in developing countries with an active research programme on human resources for health	According to surveys to be carried out in 2005	At least 30 active programmes	Owing to organizational changes the planned baseline survey was not conducted. Therefore, an achievement value cannot be established for the indicator target. Nevertheless, it is known that 16 countries in 4 regions were supported to conduct research on human resources for health

Insufficient evidence. Research projects are being conducted in a further 10 countries, but they are not structured in the same way as research programmes. The human resources for health research agenda is still in its early stages and research activities in countries are fragmented and un-coordinated. Although the WHO collaborating centres continue to focus on research, their output remains limited. The main obstacles are insufficient funding and the low priority given to human resources for health at country level. More needs to be done to strengthen the research and evidence base with a view to developing a coherent approach to learning and the sharing of best practice. The electronic online journal, *Human Resources for Health*[6] has published 27 new articles during each year of the biennium.

Effective guidelines on accreditation, licensing and certification to support mechanisms and frameworks that ensure good-quality preparation and practice of health professionals made available to countries

Indicator	Baseline	Target	Achievement
Mapping the existing regulations on accreditation, licensing and certification of health professionals	According to surveys to be carried out in 2005	At least 100 countries	Owing to organizational changes the planned baseline survey was not conducted. Therefore, an achievement value cannot be established for the indicator target. Nevertheless, it is known that 72 countries in the African, European, Eastern Mediterranean and South-East Asia Regions mapped out the existing regulations on accreditation in medical education and other health professions
Effective guidelines available to countries in at least three official languages	According to surveys to be carried out in 2005	20 countries	Owing to organizational changes the planned baseline survey was not conducted. Therefore, an achievement value cannot be established for the indicator target. Nevertheless, it is known that guidelines are available to countries in the Region of the Americas and the European Region in English, Portuguese, Spanish and Russian

[6] Accessible online at http://www.human-resources-health.com.

Indicator	Baseline	Target	Achievement
Number of countries that adopt the guidelines for the development of national regulations	According to surveys to be carried out in 2005	20 countries	Owing to organizational changes the planned baseline survey was not conducted. Therefore, an achievement value cannot be established for the indicator target. Nevertheless, it is known that 15 European Region countries adopted the guidelines

Insufficient evidence. There was insufficient evidence to determine the extent of the achievement. Progress has been uneven in this area. At global level, efforts were made to systematize the information on existing schools, accreditation and regulatory practices. A Memorandum of Understanding was signed between WHO and the University of Copenhagen to administer a global database containing directories of educational institutions for health professionals. Schools of medicine, pharmacy and public health have already been included and other health professions will be added sequentially. The directories will provide information on the distribution and accreditation of educational institutions. The Foundation for Advancement of International Medical Education and Research, the International Pharmaceutical Federation, the International Association of Medical Regulatory Authorities, the International Diabetes Federation, the World Federation of Medical Education, the World Federation of Public Health Associations and UNESCO, among others, are members of the advisory board. However, more needs to be done at country level, to ensure that global and regional guidelines are used effectively. Limited resources in some regions, combined with the lower priority assigned to this area of health workforce development compared to some other areas, as well as weaknesses in governance and oversight in the private health and education sectors, country-specific political structures, and a low level of capacity at country level to meet the demands of health partners, agencies and programmes, has constrained countries' ability to respond to efforts made by the regional offices. Attempts by the Regional Office for the Americas to map accrediting institutions for medical schools met with a low response rate, as did the efforts of two other regional offices to carry out general assessment exercises, including of regulatory practices.

Regional observatories/alliances for human resources for health set up involving development partners, professional organizations and other institutions to tackle key issues at national and regional levels that contribute to strengthening national leadership and capacity for development of such resources

Indicator	Baseline	Target	Achievement
Number of observatories/alliances established	1 global 0 regional	At least 2 regional alliances	2 regional alliances have been created

Fully achieved. The observatories on human resources for health are now a well-established mechanism for supporting evidence-based decision making. During the biennium, two regional observatories were opened in the African and Eastern Mediterranean Regions, and 11 national observatories were established in those regions. A global observatory is also in the process of being constructed. The fully functioning network of human resources for health observatories spanning 23 countries in the Region of the Americas now also supports linkages with other regions and expansion of the concept and model in other countries. In the same region, a strategic alliance exists between Brazil and Canada to support the Toronto Call to Action through technical and financial resources. The Regional Office for South-East Asia contributed to the creation of the Regional Network of Medical Councils and now provides its secretariat. Two regional alliances have been created with support from the Regional Offices for South-East Asia and the Western Pacific: the Asia-Pacific Action Alliance on Human Resources for Health and the newly-established Pacific human resources for health alliance.

Lessons learnt and actions required to improve performance

Lessons learnt:

- The endorsement of regional strategies and commitments provides evidence of political interest at global level, which it should be possible to translate into effective action at country level.
- While at global level advocacy has resulted in increased awareness and generated new levels of consensus, the translation of global and regional commitments into concrete action in countries is still lagging behind.
- Country capacity for advancing regional plans and strategies is still limited, as evidenced by the lack of designated national counterparts for human resources for health in country offices, as well as ministries of health.
- Positive results were obtained by countries that have effective leadership and strong capacity at government level to steer the process of workforce development according to the needs of the population. In order to fulfil high-level strategic commitments it is essential to be able to maintain existing capacity while training a critical mass of competent individuals at central and decentralized level.
- In many countries the evidence for decision making on human resources for health is weak. There is no active research on the subject at country level and the information and data are fragmented. Definitions need to be harmonized and common human resources for health indicators developed.

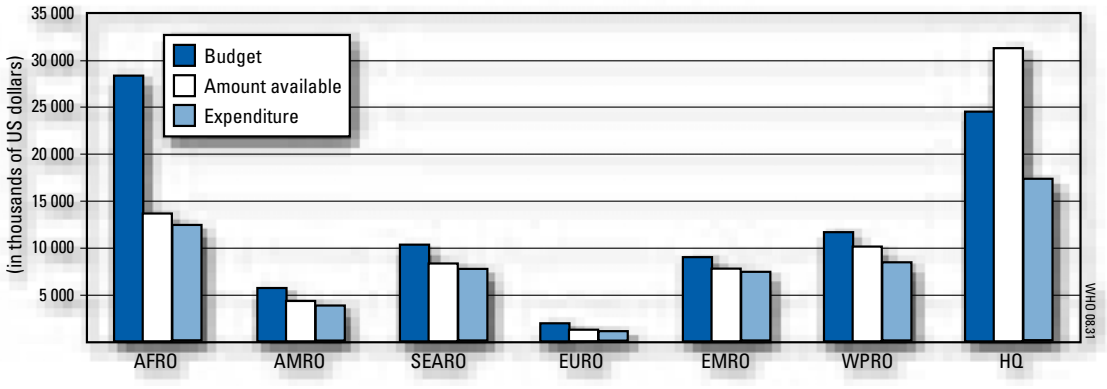
Required actions:

- A common, coordinated approach among partners and across sectors to back up the development and implementation of country-specific strategies should be facilitated. This includes continuous, more effective collaboration between WHO and existing partners, such as the Global Health Workforce Alliance and regional human resources for health alliances, as well as development partners and civil society.
- Two key actions for accelerating implementation of high-level strategic changes at country level are frequent and continuing dialogue with governments and national counterparts and a strengthening of expertise in country offices to improve WHO's ability to provide timely support.
- Priority areas that may be of technical interest to countries in 2008–2009 will be: migration and regulatory frameworks for health workforce mobility; ethical recruitment at regional and global level, the role of the public health workforce; scaling up education and training of health workers with a renewed focus on primary health care and strengthening of health systems; and increasing both research capacity and output from developing countries.

FINANCIAL IMPLEMENTATION

Human resources for health												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	11 258	16 975	28 233	9 918	3 739	13 657	48.4%	9 905	2 515	12 420	90.9%	44.0%
AMRO	3 056	2 737	5 793	3 643	701	4 344	75.0%	3 618	375	3 993	91.9%	68.9%
SEARO	7 558	2 736	10 294	6 785	1 628	8 413	81.7%	6 785	741	7 526	89.5%	73.1%
EURO	664	1 419	2 083	519	969	1 488	71.5%	519	720	1 239	83.2%	59.5%
EMRO	1 807	7 168	8 975	5 982	1 845	7 827	87.2%	5 982	1 468	7 450	95.2%	83.0%
WPRO	7 742	3 970	11 712	6 608	3 629	10 236	87.4%	6 607	1 864	8 471	82.8%	72.3%
Sub-total Regions	**32 085**	**35 005**	**67 090**	**33 455**	**12 511**	**45 966**	**68.5%**	**33 416**	**7 683**	**41 099**	**89.4%**	**61.3%**
HQ	6 902	17 656	24 558	6 289	24 968	31 257	127.3%	6 247	11 032	17 279	55.3%	70.4%
Total	**38 987**	**52 661**	**91 648**	**39 744**	**37 479**	**77 223**	**84.3%**	**39 663**	**18 715**	**58 378**	**75.6%**	**63.7%**

Human resources for health



* *Amount available figures are not represented as such in the Financial Report and Audited Financial Statements, but include elements of both income received during 2006-2007 and amounts carried forward from the opening fund balances at 1 January 2006.*

Policy-making for health in development (HSD)

WHO objective(s)

To maintain and further secure the centrality both of health to a wide range of development processes at national, regional and international levels, and of ethical, economic and human rights analysis to the achievement of just and coherent policies and laws at national, regional and international levels.

Indicator(s) and achievement

- *Recognition of the role of health in national development in political and development forums, and its translation into policies, plans and budgets at country level.* More countries are seeking and obtaining WHO's advice and support in developing national health plans, policies and more efficient and equitable health systems. More countries are developing Medium-Term Expenditure Frameworks for the health sector in line with national poverty reductions strategies and macroeconomic frameworks. Following on from the High-Level Forum on the Health Millennium Development Goals, the Harmonization for Health in Africa initiative was established in 2006. There has been increased recognition by donors of the role of health in exploring ways of increasing aid effectiveness in line with the principles contained in the 2006 Paris Declaration on Aid Effectiveness. WHO has contributed towards building the International Health Partnership, which was launched in September 2007, and has been involved in a range of similar initiatives that aim to increase the effectiveness of development assistance, focus greater attention on health systems, increase the predictability of aid funding, and establish systems for strengthening the mutual accountability of governments and their development partners.
- *Recognition of ethics, law, trade and human rights in WHO consultations and in political forums, and their translation into policies, plans and action at country level.* Greater attention has been paid to policy coherence within and between government sectors and in multilateral forums in order to create an environment that is conducive to the advancement of health goals at national and international level. Expertise and guidance on ethics, trade, human rights and law is increasingly being sought and provided to countries at national level and in the context of intergovernmental processes and WHO consultations.

Main achievements

- There has been an increase in the number of countries that are expanding the role of health in their national development processes and which have concurrently begun to use and tailor policies and planning instruments to health development analyses.
- A number of health and development partnerships have been established or strengthened with, among others, United Nations agencies, individual countries, national human rights institutions, national ethics committees and nongovernmental organizations.
- A number of guidance documents have been issued in connection with: the final report of the Commission on Social Determinants of Health, fact sheets on health and human rights, a report on ethical considerations in the development of a public health response to pandemic influenza, and a methodological framework for assessing trade in health services.

- The strengthening of regional offices has led to increased support for training and capacity building in countries in the areas of equity, human rights, trade, ethics and health law.
- WHO has contributed to the drafting and adoption of several policy documents, some of which deal with health-related human rights. They include contributions to the general comments of United Nations Human Rights Treaty Bodies and the reports of United Nations Special Rapporteurs, publications on trade and health, for example on international trade in health services,[1] and on global health legislation, for example the *International Digest of Health Legislation*.

Achievement of Organization-wide expected results

Strengthened country capacity to ensure that national development plans and budgets, Poverty Reduction Strategy Papers, public sector reforms and sector programmes (including sector-wide approaches) and intersectoral mechanisms support increased investments in health and improved health outcomes, including achievement of the health-related Millennium Development Goals, and focus on the impact of any proposed measures on poor, vulnerable and marginalized people

Indicator	Baseline	Target	Achievement
Proportion of low-income countries in which WHO has played an acknowledged role in enabling national authorities to develop Poverty Reduction Strategy Papers, national poverty reduction plans, sector programmes that include a coherent and costed approach to health of the poor	Less than 10% of eligible countries	50% of eligible countries	In 90% of the 84 countries that have prepared Poverty Reduction Strategy Papers and in which WHO has a presence, the Organization has played an active or leading role in assisting governments to prepare the health component
Proportion of low-income countries in which WHO has made an acknowledged contribution to assessing equity in the preparation of national health plans	20% of eligible countries in 2 WHO regions (South-East Asia and Western Pacific)	40% of eligible countries in each region	40% of low- and middle-income countries (67)

Partly achieved. Fresh data have been collected and new methods devised for analysing existing data. High-profile policy meetings were organized, mainly in collaboration with the Regional Offices for the African and South-east Asia Regions, to lay the groundwork for carrying out further country-specific analysis to assist countries in planning for the 2008–2009 biennium. Conceptual and operational frameworks for analysing equity and social determinants of health at national and global level were provided to the Commission on Social Determinants of Health. These frameworks, in which emphasis was placed on vulnerable and marginalized people, and which also documented the economic and social gradient without focusing exclusively on the poorest populations, clearly had an influence on the direction pursued in the Commission's draft report and preliminary recommendations. Regional offices have encouraged community-based initiatives and national policies designed to address equity in health systems.

[1] Blouin, C. et al. *International trade in health services and the GATS: current issues and debates.* Washington D.C., The International Bank for Reconstruction and Development/The World Bank, 2006.

WHO fully engaged in global dialogues and dissemination of best practices and processes on development, particularly in relation to the Millennium Development Goals and other partnership-based mechanisms with the aim of integrating health in the mainstream of development activities, increasing resources, and improving the effectiveness and equity of aid-delivery mechanisms in the health sector

Indicator	Baseline	Target	Achievement
Proportion of low-income countries in which a set of indicators on effectiveness of aid for health, recommended by WHO, is applied	-	Indicators on aid effectiveness designed and applied to 60% of eligible countries	Indicators on aid effectiveness were not designed
Existence of global system for tracking of resources	-	Tracking system established and functional	Recommendations for a more integrated resource tracking system have been put forward but not yet implemented

Partly achieved. Rather than establish a new system, it was agreed that indicators on aid effectiveness would be developed in parallel with the work of monitoring the Paris Declaration. It was also agreed that monitoring aid effectiveness in health should be part of overall performance monitoring. A common framework agreed by countries and donors under the auspices of the International Health Partnership has now been developed. A study on aid effectiveness in the health sector will be conducted in Accra as part of a series of country case studies on aid effectiveness. A working group convened by the OECD/Development Assistance Committee and the Center for Global Development, in which WHO participated, recommended a more integrated resource tracking system, but this has yet to be implemented. WHO continues to track resource allocation and use through national health accounts. Additionally, new analyses of aid allocation have been prepared using data from the OECD/Development Assistance Committee Creditor Reporting Scheme.

Endorsement by WHO's governing bodies of the recommendations of WHO's commission on equity and social determinants of health and adoption by countries

Indicator	Baseline	Target	Achievement
Number of country programmes or activities that incorporate in their operations recommendations of WHO's commission on equity and social determinants of health	-	20 programmes or activities that incorporate the recommendations in their operations	Pending release of the final report
Recommendations of WHO's commission on equity and social determinants of health endorsed by WHO's governing bodies	Drawing up of recommendations	Recommendations endorsed by WHO's governing bodies	Pending release of the final report

Deferred. As a result of the work of the Commission on Social Determinants of Health during the 2006–2007 biennium, several programmes and activities at headquarters and in all six regions were designed in order to highlight health inequities and promote the development of strategies and policies to tackle these inequities using a social determinants approach. This has led to the production of discussion papers, changes in governmental policy and increased cooperation between the public and private sectors.

Implementation of WHO's strategy on health and human rights initiated in order to advance globally the concept of health as a human right; capability strengthened at regional level to provide support to Member States for integrating a human-rights approach into health-related policies, laws, and programmes

Indicator	Baseline	Target	Achievement
Extent of progress in implementing WHO's strategy on health and human rights	WHO's strategy on health and human rights formulated	Approval of the strategy on health and human rights by WHO's governing bodies	Organization-wide task force established and draft outline of WHO health and human rights strategy developed
Number of national partnerships forged, tools made accessible, and projects under way to integrate a human-rights approach into health development	4 global tools available to regions and countries	Staff tools and training available in 3 regional offices to support countries in implementing WHO's strategy on health and human rights Implementa-tion of the strategy under way in 3 countries in each region	Full-time staff in 2 regional offices and part-time staff in all other regional offices; training conducted in four regional offices Country-based staff in 3 regions; partnerships forged with relevant United Nations agencies, regional human rights bodies and national human rights institutions

Partly achieved. Although a WHO strategy on health and human rights was not approved, a number of activities and projects have been implemented, including training modules and an e-learning course. Tools have been disseminated, including a handbook for health policy makers on addressing poverty reduction strategies from a human rights perspective, and a new series of fact sheets on health and human rights has been produced in collaboration with the Office of the High Commissioner for Human Rights. Advocacy materials, including a video[2] and cartoons on health rights, have been disseminated in order to generate greater awareness and understanding of health rights. Closer partnerships have been forged with relevant United Nations bodies such as the United Nations Permanent Forum on Indigenous Issues.

Increased capacity at country, regional and global levels and within the Organization to measure, assess and act on cross-border risks to public health in the context of globalization, focusing on implications for population health of multi- and bi-lateral trade agreements

Indicator	Baseline	Target	Achievement
Extent of capacity to assess and act on health implications of trade and globalization	Number of countries with ministerial mechanisms for trade and health: not known Staff time in regions dedicated to issues related to trade and health: not known	4 countries in each region with active interministerial mechanisms for trade and health Half-time trade and health adviser in 4 regional offices	2 in the Region of the Americas; 2 in the South-east Asia Region; and 2 in the Western Pacific Region 3 advisers: one each in the Eastern Mediterranean, South-east Asia and Western Pacific Regions

Partly achieved. A number of activities and projects have been implemented following the adoption by the Fifty-ninth World Health Assembly of the resolution on international trade and health,[3] which have contributed towards the scaling up of trade and

[2] *Health – My Right.* Released by the World Health Organization to commemorate International Human Rights Day 2006.
[3] Resolution WHA59.26.

health related activities throughout the Organization. A diagnostic tool and companion workbook is being prepared to enable policymakers to develop national policies and strategies on trade and health and to identify their capacity-building needs in this area. Annual training courses on health policy in a globalizing world and global health diplomacy, as well as the inclusion of a health module in the World Bank Institute's *E-learning course: trade in services and international agreements*, have contributed towards increasing the capacity of country and WHO staff. Key documents have been prepared, including the updating *of International Trade in health Services and the GATS: current issues and debates*,[4] working papers on intellectual property, foreign policy and health and global health diplomacy, and legal reviews on multilateral trade agreements and health. Capacity-building support to WHO Representatives has been increased through the inclusion of trade and health plenary and training sessions in global WHO Representatives meetings. Technical support in the area of trade and health has also been given to selected countries.

Support provided at the three levels of the Organization for analysing the ethical aspects of health and research; support provided to countries through tools, standards, and guidelines for incorporating an ethical analysis into health services delivery, research and public-health activities

Indicator	Baseline	Target	Achievement
Number of global and regional programmes or activities that include ethics in plans, activities and products	5	10	15
Extent to which countries integrate ethics into health programmes and policies	2–3 topics addressed in some 10% of countries	At least 5 topics addressed in some 40% of countries	5 topics addressed in 50% of countries

Fully achieved. A number of training activities have taken place in all regions and guidance documents have been issued on a wide range of subjects, covering: ethics in research, including the role of ethics research committees in many low- and middle-income countries and the incorporation of ethical considerations into research in the pharmaceutical sector; pandemic influenza preparedness and planning; equitable access to care and treatment, testing and counselling for people suffering from HIV; organ and tissue transplantation; and palliative care. In particular, partnerships with United Nations organizations, as well as with regional intergovernmental and nongovernmental organizations, have contributed towards the progress made in this area.

Strengthened capacity of Member States to formulate and implement legislation and regulations to protect and promote public health, through technical cooperation and information exchange at country, regional and global levels

Indicator	Baseline	Target	Achievement
Number of countries that have formulated health law to meet contemporary public-health priorities	To be established on the basis of a survey to be conducted in the last quarter of 2005	At least 2 countries in each region	2 countries in each region
Availability of model public-health legislation formulated in light of the Millennium Development Goals	Framework for model law defined	Model law/guide completed	Progress made towards completion of guide: expected in 2008

Partly achieved. WHO staff at headquarters and in regional offices have provided advice and organized missions to assist countries in preparing their national health legislation. Additionally, 3200 new examples of regional, national and international health legislation have been collected, analysed and summarized or translated into some 50

[4] Blouin, C. et al. *International trade in health services and the GATS: current issues and debates*. Washington D.C., The International Bank for Reconstruction and Development/The World Bank, 2006.
[5] Croft, Sir John et al. *Guidelines for the management of drug-resistant tuberculosis*. Geneva, World Health Organization, 1997.

languages through the WHO International Digest of Health Legislation. Progress has been made in drafting the model public health act, which will focus on the role of legislation in strengthening primary health-care systems in order to increase the momentum towards achieving the health-related Millennium Development Goals. It will also address concerns about the environment and the protection of human health, and assist in the development of new international instruments to protect and promote health. The regional offices have been involved, as well as a growing the number of project partners in health ministries and in research and academic institutions. Other activities, such as the preparation of a chapter on health law for the *Guidelines for the management of drug-resistant tuberculosis*,[5] have also been undertaken.

Lessons learnt and actions required to improve performance

Lessons learnt:

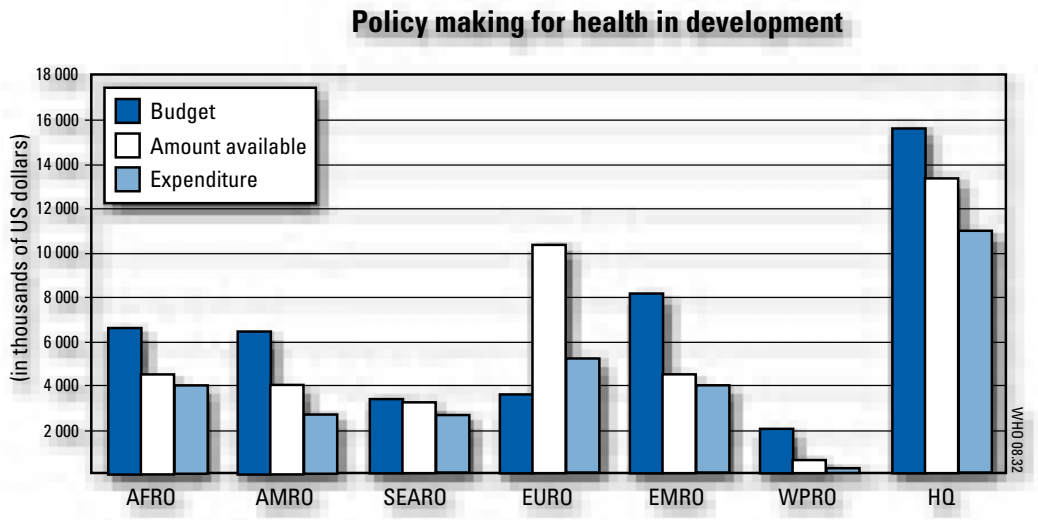
- The capacity of ministries of health to address questions of ethics, equity, trade, social determinants of health, human rights and health legislation needs to be strengthened, and their efforts to engage with other sectors encouraged so as to ensure policy coherence and efficient national health systems.
- It is important to maintain and establish partnerships with a range of stakeholders that have an interest in questions of ethics, equity, trade, social determinants of health, human rights and health legislation.
- Sustainable financing is needed to facilitate policy development and the implementation of recommendations at country level.
- Baseline data needs to be more carefully recorded and attainable targets selected as indicators for tracking progress.

Required actions:

- To continue to support ministries of health and other relevant stakeholders so that national and international health agendas address questions relating to ethics, equity, trade, social determinants of health, human rights and health legislation.
- To continue to provide regional offices and country-level actors with tools and guides to better equip them to address cross-cutting issues.
- To continue to actively seek sustainable funding for carrying out work in these areas.
- To continue to forge sustainable partnerships with a range of stakeholders both globally and nationally.

FINANCIAL IMPLEMENTATION

Policy making for health in development												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	3 414	3 135	6 549	1 929	2 579	4 508	68.8%	1 931	1 999	3 930	87.2%	60.0%
AMRO	4 840	1 511	6 351	1 737	1 100	2 838	44.7%	1 731	917	2 648	93.3%	41.7%
SEARO	2 645	728	3 373	2 473	816	3 289	97.5%	2 473	153	2 626	79.8%	77.9%
EURO	1 144	2 356	3 500	814	9 460	10 274	293.5%	814	4 377	5 191	50.5%	148.3%
EMRO	1 150	6 929	8 079	3 355	1 138	4 493	55.6%	3 356	643	3 999	89.0%	49.5%
WPRO	0	2 000	2 000	76	563	639	32.0%	77	246	323	50.5%	16.2%
Sub-total Regions	**13 193**	**16 659**	**29 852**	**10 384**	**15 657**	**26 041**	**87.2%**	**10 382**	**8 335**	**18 717**	**71.9%**	**62.7%**
HQ	2 967	12 544	15 511	4 448	8 852	13 300	85.7%	4 443	6 472	10 915	82.1%	70.4%
Total	**16 160**	**29 203**	**45 363**	**14 832**	**24 510**	**39 342**	**86.7%**	**14 825**	**14 807**	**29 632**	**75.3%**	**65.3%**



* *Amount available figures are not represented as such in the Financial Report and Audited Financial Statements, but include elements of both income received during 2006-2007 and amounts carried forward from the opening fund balances at 1 January 2006.*

Essential medicines (EDM)

WHO objective(s)

To frame, implement and monitor national medicines policies aiming at: increasing equitable access to essential medicines, particularly for high-priority health problems and for poor and disadvantaged populations; ensuring the quality, safety and efficacy of medicines by developing international standards and supporting the implementation of effective regulation in countries; and improving rational use of medicines by health professionals and consumers.

Indicator(s) and achievement

- *Number of countries that have established a national medicines policy, either new or updated, within the past 10 years*. At least 132 countries.

Main achievements

- Many countries have developed or updated their national medicines policies to incorporate all the components of the essential medicines programme. Many countries received assistance in developing, implementing and monitoring their medicines policies.
- Twenty-seven global standards have been developed, including quality standards for new essential medicines for HIV/AIDS and malaria, standards for medicines for children, and United Nations interagency standards for medicine procurement agencies.
- National medicine pricing surveys have been completed in 45 countries; mapping of stakeholders involved in supplying medicines has been carried out in 10 African countries; best practices in supply management have been studied in over 20 countries; the first Model List of Essential Medicines for Children has been issued; and a global programme to combat counterfeit medicines has been launched.
- Clear guidance on designing a national medicines policy exists at global level and has been broadened through the inclusion of access to essential medicines as a human right and innovative thinking on public health, innovation and intellectual property rights.
- The Sixtieth World Health Assembly adopted resolutions on promoting rational use of medicines[1] and on better medicines for children.[2]
- Following the report of the Commission on Intellectual Property, Innovation and Public Health, the Fifty-ninth World Health Assembly adopted resolution WHA59.24, which established an Intergovernmental Working Group on Intellectual Property, Innovation and Public Health. The Intergovernmental Working Group has prepared a draft global strategy and plan of action, which is being negotiated by about 140 Member States and will be finalized for submission to the Sixty-first World Health Assembly at the Intergovernmental Working Group's resumed second session in April 2008.

[1] Resolution WHA60.16.
[2] Resolution WHA60.20.

Achievement of Organization-wide expected results

Implementation and monitoring of medicines policies based on the concept of essential medicines, monitoring the impact of trade agreements on access to quality essential medicines, and building capacity in the pharmaceutical sector all advocated and supported

Indicator	Baseline	Target	Achievement
Number of countries that have plans for implementing national medicines policy, either new or updated, within the past five years	49 of 103	62	106
Number of countries integrating flexibilities for protection of public health in the Agreement on Trade-related Aspects of Intellectual Property Rights into national legislation	32 of 105	47	61 excluding data from the Regional Offices for the Americas and the Eastern Mediterranean

Fully achieved. Nearly one hundred countries are developing or implementing national medicine policies, including Pacific Island and Caribbean countries. An increasing number of countries are making use of the flexibilities in the Trade-related Aspects of Intellectual Property Rights (TRIPS) agreement. For example, in the South-east Asia Region, national policies developed in the previous decade may need to be updated to derive maximum benefit from recent developments and generate clearer evidence on the efficacy of interventions. There has been a lack of resources and donor support for comprehensive national essential medicines programmes, as opposed to the vertical, disease-oriented programmes which are in operation in many developing countries and which tend to ignore the need for medicines to treat common killer diseases, such as diarrhoea and acute respiratory tract infections.

Adequate support provided to countries to promote the safety, efficacy, quality and sound use of traditional medicine and complementary and alternative medicine

Indicator	Baseline	Target	Achievement
Number of countries regulating herbal medicines	39 of 129	47	65

Fully achieved. During the last biennium, WHO, with interested countries, coordinated the establishment of an International Regulatory Cooperation for Herbal Medicines to facilitate the sharing of regulatory information. Seven WHO monographs or sets of technical guidelines on herbal medicines have been either finalized or published to assist countries in controlling the safety and quality of herbal medicines. WHO has also developed basic training and safety guidelines for the seven most frequently used traditional, complementary and alternative medicine practices and therapies. These guidelines have promoted qualified practice and facilitated the establishment of national regulation and registration mechanisms for traditional, complementary and alternative medicine practices as a preliminary step towards integration of traditional medicine into national health systems, including primary health care.

Guidance provided on financing the supply and increasing the affordability of essential medicines in both the public and private sectors

Indicator	Baseline	Target	Achievement
Number of countries with public spending on medicines below US$ 2 per person per year	24 of 80	16	17 excluding data from the Regional Offices for the Eastern Mediterranean and South-east Asia
Number of countries with generic substitution allowed in private pharmacies	99 of 132	106	106 excluding data from the Regional Offices for the Eastern Mediterranean and Western Pacific

Fully achieved. There has been an increase in the number of national surveys on the availability, price and affordability of essential medicines based on the standard WHO/Health Action International methodology. Several across-country analyses have been performed on the results, for example, those on medicines for chronic diseases. Work is continuing on using these outcomes for establishing national price monitoring systems and developing policy guidance in order to reduce prices. No work has been undertaken on medicine financing or the promotion of generic policies because of a lack of human and financial resources. Surveys in many countries show that availability of low-priced generics is very limited, which supports the case for promoting generic policies and other measures to improve affordability and availability of essential medicines.

Efficient and secure systems for medicines supply promoted in order to ensure continuous availability of essential medicines

Indicator	Baseline	Target	Achievement
Number of countries with public-sector procurement based on a national list of essential medicines	84 of 127	93	138 excluding data from the Regional Office for the Eastern Mediterranean

Partly achieved. Two intercountry studies were completed on best practices in medicine supply management in the public and nongovernmental sectors. The outcomes of these studies are now being used to promote a comprehensive medicine supply management system as opposed to the vertical, disease-oriented and donor-driven supply systems currently in place in many countries. Interagency global quality standards for medicine procurement agencies have been developed and can now be used as the basis for improving national systems. The target is classified as partly achieved because the indicator only reflects part of the problem. In reality, WHO has not been sufficiently active or successful in promoting a comprehensive procurement and supply system as a more effective alternative to disease-oriented vertical supply programmes.

Global norms, standards and guidelines for the quality, safety and efficacy of medicines strengthened and promoted

Indicator	Baseline	Target	Achievement
Number of international non proprietary (generic) names assigned in the biennium	-	300	240
Number of psychotropic and narcotic substances reviewed for classification for international control in the biennium	-	4	9
Number of priority medicines assessed and inspected for United Nations procurement	-	100	65

Partly achieved. Twenty-seven new global quality control specifications have been developed and adopted, including for new essential medicines for HIV/AIDS and malaria, and medicines for children. A total of 240 international non-proprietary names in seven languages were assigned to new medicines. Of the 115 new products which were submitted for assessment and inspection, 65 have been prequalified, which considerably increases the choice of assured quality medicines. The number of new priority medicines that have been prequalified for United Nations procurement is lower than planned, because many manufacturers find it difficult to pass the very strict WHO requirements. For example, in 2007 alone, 46 global inspections were carried out in seven different countries and 511 assessment reports were written on submitted product dossiers. An extensive support programme has now been introduced for manufacturers of priority medicines in developing countries.

Instruments for effective medicine regulation and quality-assurance systems promoted in order to strengthen national regulatory authorities

Indicator	Baseline	Target	Achievement
Number of countries operating a basic regulatory system	90 of 130	96	137 excluding data from the Regional Office for the Eastern Mediterranean

Fully achieved. It is too early for information to be available on the status of regulatory agencies throughout the world, as the assessment tool is still under development and not all agencies have been evaluated. In general, support for national agencies has increased, especially through the capacity building component of the WHO/United Nations Prequalification Programme. Despite hopeful signs in several developing countries, for example, Tanzania, Uganda and Zimbabwe, in many countries there is a lack of political recognition of the importance of national medicine regulation and low investment in human and financial resources as a result.

Awareness raising and guidance on cost-effective and sound use of medicines promoted, with a view to improving use of medicines by health professionals and consumers

Indicator	Baseline	Target	Achievement
Number of countries that have a national list of essential medicines updated within the past five years	82 of 114	85	At least 117 countries

Fully achieved. The Sixtieth World Health Assembly adopted resolutions on rational use of medicines[3] and better medicines for children.[4] In the case of the latter, the first WHO Model List of Essential Medicines for Children has been issued. However, the waste of resources globally, both medical and economic, arising from irrational use of medicines, as well as increasing antimicrobial resistance, remain largely untackled, despite the availability of several well-tried evidence-based interventions. Neither do governments or international donors seem willing to establish national programmes to resolve the problems and WHO has been prevented from taking robust action by a lack of resources in some regions.

Lessons learnt and actions required to improve performance

Lessons learnt:

- The WHO/United Nations Prequalification Programme has become one of the main vehicles for regulatory capacity building in developing countries, through

[3] Resolution WHA60.16.
[4] Resolution WHA60.20.

the many training programmes and hands-on involvement of an increasing number of assessors and regulators from developing countries. The Programme's clear criteria support a public-health approach to innovation and serve as a guide to the industry in its development of missing essential medicines.

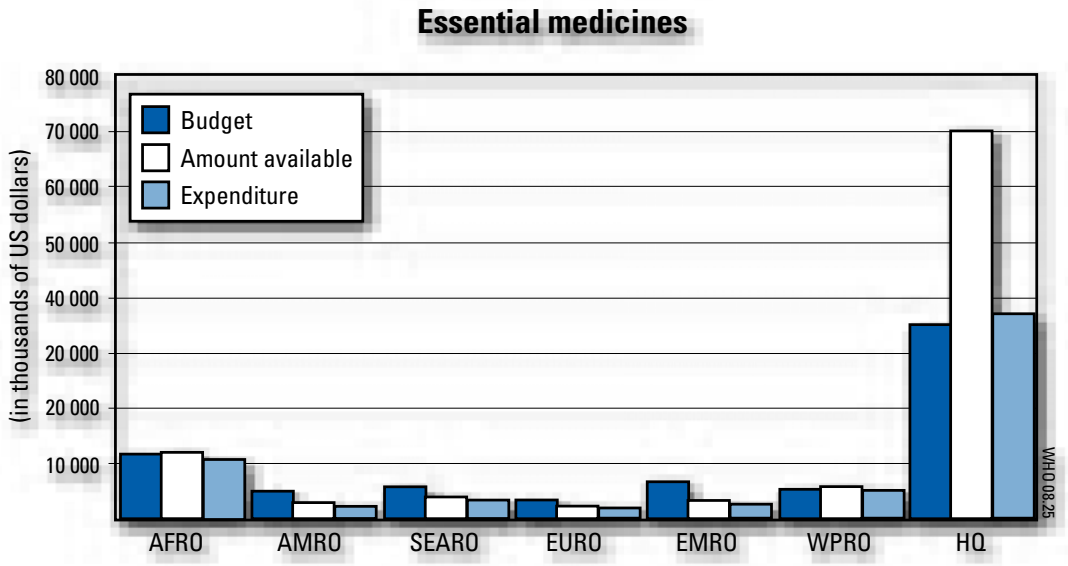
- The presence of over 30 national Programme officers facilitates the development and implementation of national medicines policies and programmes. These national Programme officers constitute the next generation of global technical experts and WHO should find ways to support them in their international careers.
- There is still insufficient national recognition of the potential risk to health from a lack of regulation, and the extent of the waste, both medical and economic, arising from irrational use of medicines by prescribers and consumers. Consequently, governments underinvest in their national regulatory agencies and are unwilling to introduce national programmes to promote rational use of medicines, despite the availability of well-evidenced interventions and the enormous potential for economic savings.

Required actions:

- Governments need to invest more in developing and strengthening national medicine regulation and in programmes to promote rational use of medicines by prescribers and consumers. Both approaches have the potential to increase patient safety and promote cost-effective use of limited resources.
- WHO and the international donor community should further promote and support horizontal, comprehensive medicine systems in countries that combine and strengthen the common medicine components of the many vertical disease-oriented programmes.
- WHO's global normative functions and policies in the field of pharmaceuticals provide essential guidance to governments and international organizations, and are widely respected for their scientific basis and political independence. These unique functions should be considered as a global good and their further development seen as an essential component of WHO's global mandate.

FINANCIAL IMPLEMENTATION

Essential medicines												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	3 556	7 944	11 500	3 964	7 760	11 724	101.9%	3 962	6 387	10 349	88.3%	90.0%
AMRO	687	3 941	4 628	1 189	1 613	2 802	60.6%	1 186	1 351	2 537	90.5%	54.8%
SEARO	2 366	3 134	5 500	2 712	1 158	3 870	70.4%	2 712	461	3 173	82.0%	57.7%
EURO	896	2 354	3 250	870	1 299	2 169	66.8%	870	1 105	1 975	91.0%	60.8%
EMRO	1 468	4 938	6 406	1 155	2 109	3 265	51.0%	1 155	1 514	2 669	81.8%	41.7%
WPRO	1 746	3 254	5 000	1 827	3 738	5 565	111.3%	1 827	3 068	4 895	88.0%	97.9%
Sub-total Regions	**10 719**	**25 565**	**36 284**	**11 717**	**17 678**	**29 395**	**81.0%**	**11 712**	**13 886**	**25 598**	**87.1%**	**70.5%**
HQ	6 310	28 274	34 584	7 095	62 760	69 855	202.0%	7 095	29 706	36 801	52.7%	106.4%
Total	**17 029**	**53 839**	**70 868**	**18 812**	**80 438**	**99 250**	**140.1%**	**18 807**	**43 592**	**62 399**	**62.9%**	**88.1%**



* *Amount available figures are not represented as such in the Financial Report and Audited Financial Statements, but include elements of both income received during 2006-2007 and amounts carried forward from the opening fund balances at 1 January 2006.*

Essential health technologies (BCT)

WHO objective(s)

To establish safe and reliable services that apply essential health technologies and use biological products through the adoption of basic operational frameworks covering policy, quality, safety, access and use.

Indicator(s) and achievement

- *Number of countries making use of the basic operational frameworks for the integration of essential health technologies into their health systems*. Basic operational frameworks encompass norms, standards, guidelines, information and training materials and other sets of recommendations. They provide support to Member States in establishing and optimizing health technologies and in fostering research. Health technologies include blood and blood transfusion safety, injection safety, transplantation, emergency and essential surgical care, diagnostic imaging, medical devices, diagnostics and laboratory technology, and eHealth for health-care delivery. With technical support from WHO and other partners, a total of 88 countries in five regions have used basic operational frameworks for integrating essential health technologies into their health systems as part of national policy on health technology management.

Main achievements

- WHO's bulk procurement scheme facilitated the acquisition of high quality HIV diagnostics by 45 Member States and resulted in substantial savings while ensuring quality. A laboratory network was established in the African Region for early detection of HIV and follow-up of infants born to HIV-positive mothers, and regional external quality assurance schemes for laboratory markers were introduced in the Eastern Mediterranean Region. Technical support for the selection and procurement of laboratory technologies, as well as guidelines on CD4 technologies and procurement and supply chain management, was provided to countries.
- World Blood Donor Day was celebrated on 14 June 2007 and a Global Initiative on Safe Blood for Safe Motherhood was launched simultaneously. Twenty-nine additional countries have developed national blood policies and strategic plans for blood safety, bringing the total to 68, and 50 countries have achieved 100% voluntary blood donation.
- Forty-four countries have implemented comprehensive policies and strategies on injection safety, and a network of laboratories controlling the quality and safety of injection devices in 23 Latin American countries has been established.
- Collaboration with health authorities and scientific and professional bodies has led to increased global awareness of the need for ethical practices in transplantation. This has resulted in legislative measures to ban commercial transplantation and transplant tourism, for example in China and Pakistan.

- The mandate for the programme on medical devices was reinforced by the adoption by the Sixtieth World Health Assembly of resolution WHA60.29 on health technologies. Direct technical support for the drafting of policies on medical devices was supplied to more than 20 Member States by regional offices and headquarters. A project on priority medical devices was also launched, with the support of the Government of the Netherlands, to review and analyse current and possible future gaps in the availability and accessibility of medical devices.
- In collaboration with regional and country offices and ministries of health, members of the Global Initiative for Emergency and Essential Surgical Care, including academics, economists and representatives of international and nongovernmental organizations, provided support to 24 countries in all six regions.

Achievement of Organization-wide expected results

Appropriate strategies promoted and support provided for blood safety and availability, injection safety and prevention of blood-borne infections, including HIV and hepatitis B and C, in health-care settings

Indicator	Baseline	Target	Achievement
Number of countries having implemented national strategies on blood safety and availability, including 100% voluntary blood donation and 100% testing for HIV and hepatitis B and C viral markers	39 countries	12 additional countries	29 additional countries developed and/or implemented national blood policies making a total of 68 countries that have done so; 50 countries achieved 100% voluntary blood donation
Number of countries having implemented national strategies on injection safety and related infection control for the prevention of blood-borne infections in health-care settings	No data available	6 additional countries	44 additional countries
Number of regional networks for strengthening of national regulatory authorities for blood products involving priority countries	1 regional network established	2 regional networks established and strengthened	12 countries finalized their legislation on blood transfusion
Number of WHO international biological reference materials established or under development	110	Additional 5	15 additional WHO international biological reference preparations established

Fully achieved. Several WHO initiatives and events were launched, such as the voluntary non-remunerated blood donor programme, World Blood Donor Day, and quality management for blood transfusion services. In addition, WHO supported countries in formulating national blood policies, establishing sustainable blood transfusion services and implementing integrated strategies on blood safety. With the help of funding from the United States President's Emergency Plan for HIV/AIDS Relief, technical support was provided for blood safety projects in Ethiopia, Guyana, Haiti and Namibia, and tools and materials have been developed for strengthening national blood transfusion services. The provision of technical assistance has led to the development of national blood policies and plans in 68 countries. Expert consultations, interregional workshops and training workshops were organized on various aspects of blood transfusion safety, including establishing national blood programmes, quality management and voluntary blood donation, in which more than 100 blood transfusion experts and representatives from over 130 countries were involved. The Global Consultation on Universal Access to Safe Blood Transfusion focused specifically on global blood safety and its availability in the context of the health-related Millennium Development Goals, while the Global Collaboration for Blood Safety concentrated on the development of haemovigilance, surveillance and alert networks. Global Blood Safety Indicators have been designed and reports on the Global Database on Blood Safety have been published by the Regional Offices for Africa and the Americas.

Most regional offices have implemented injection safety policies and strategies, while the majority of African countries have established systems for monitoring adverse events related to injections. In the South-east Asia Region, ten out of 11 countries are now exclusively using auto-disable syringes in immunization services, and the region-wide plan for controlling the quality and safety of syringes is now operational in 23 countries. In addition, six regulatory agencies for medical devices have formed a network of laboratories for testing syringes. The revised injection safety assessment tool, which now includes indicators on phlebotomies, intravenous injections and infusions, and lancet procedures, has been pilot tested in two countries. This tool will help countries to identify the risks related to all injection routes, and to plan and implement corrective action accordingly. Fifteen additional WHO international biological reference preparations for the control of blood products and related *in vitro* diagnostic devices have been established. Among them, the WHO international reference preparations for the detection of Hepatitis C RNA and Hepatitis B DNA in nucleic acid amplification tests underpin international safety regulations in blood products.

Capacity strengthened and quality and safety of, and access to, appropriate diagnostics, medical devices, laboratory services (including basic laboratory tests and screening for HIV, hepatitis B and C) and cell, organ and tissue transplantation services improved

Indicator	Baseline	Target	Achievement
Number of countries and partners using WHO's list of prequalified diagnostics	24 countries and 5 partners	30 countries and 8 partners	45 countries and 5 partners that procure through WHO
Number of laboratories participating in external quality-assessment schemes and percentage with good or improved performance	600	700 of which 50% with good or improved performance	700 laboratories participated in a WHO external quality assessment scheme. 65 % showed good or improved performance
Number of targeted countries with strengthened national regulatory systems on medical devices	6 countries	At least 1 country in each region	28 countries in 4 regions
Number of targeted countries using WHO core standards as a basis of national transplantation standards	To be determined, as defined from the global allogeneic and xenogeneic transplantation database available in the last quarter of 2005	10% of targeted countries in each region	10 out of 12 targeted countries in 6 regions
Number of targeted countries with access to basic transplantation services	Nil	10% of targeted countries in each region	16 countries in 6 regions

Fully achieved. WHO's bulk procurement scheme has been used by Member States to obtain diagnostics for detection of HIV, HBsAg, HCV and malaria. Other United Nations agencies also rely on the list's recommendations for choosing diagnostics of an assured quality, for example in 2007, UNICEF procured more than 10 million HIV tests. The number of laboratories participating in external quality assessment schemes increased in all regions. These schemes were used for assessing basic haematology (including blood parasite identification), blood coagulation, CD4 enumeration and serology for HIV, HBsAg and HCV. Good or improved performance was observed in 65% of the participating laboratories. Four countries, with WHO's support, have strengthened their regulatory systems on medical devices. However, further advocacy is needed to increase awareness of the need for specific regulations for medical devices, as well as to strengthen existing systems. Progress in establishing regulatory systems is likely to be slow as all activities are linked to national legislative processes.

WHO has acted as facilitator in work on adverse event reporting and has co-organized training courses on the exchange of regulatory information on medical devices through international networks in which representatives from more than 20 countries in three regions have taken part. The Organization has also participated in efforts to combat counterfeit medical products, including medical devices.

With regard to promoting safe and suitable transplantation services, countries previously known to be major hosts of trafficking and transplant tourism are now aligning themselves with the WHO principles incorporated in new or updated legislation. Access to basic transplantation services has improved as a result of increased organ and tissue donations, in particular from deceased donors. A guidance document for Member States, including draft updated WHO guiding principles on human organ transplantation, has been prepared and is ready for submission to the Executive Board. The guidelines for cell and tissue banking services and for human xenotransplantation have been disseminated. A global database on donation and transplantation has been compiled in collaboration with the Spanish Organización Nacional de Trasplantes. Tools to encourage vigilance and facilitate surveillance of human material for transplantation at global level are being finalized. Steps have been taken, in collaboration with country and regional offices, to prevent organ trafficking and human exploitation in transplantation for commercial purposes. In particular, China and Pakistan have adopted legislation that prohibits commercial transplantation and transplant tourism. The Transplantation Society and other relevant scientific and professional societies, supported by WHO, have issued global guidance documents for professionals.

Guidance and support provided for implementation of safe, efficient and appropriate essential emergency and surgical care at first-level referral health facilities

Indicator	Baseline	Target	Achievement
Number of targeted countries using training material on surgery and anaesthesia for training health providers at district hospitals	Training material prepared and tested	2 countries in each region	24 countries

Fully achieved. Twenty-four countries are using training material on surgery and anaesthesia for training health providers in district hospitals. Training on building capacity for emergency preparedness in these countries has always been conducted in collaboration with regional and country offices, ministries of health and local partners. For example, workshops, organized jointly with ministries of health, were held on the use of locally adapted integrated management of emergency and essential surgical care toolkits in resource limited settings, followed by cascade training in primary health-care facilities. Meetings with cross-cutting themes have also been held, for example on Buruli ulcer, injury prevention, maternal and child health, emergencies and HIV prevention. In June 2007, WHO, with Global Health Sciences at the University of California, San Francisco, the World Bank, the Rockefeller Foundation and the Karolinska Institute, co-hosted a conference on increasing access to surgical services in resource-constrained settings in sub-Saharan Africa.

Support provided to capacity building and to development of standard procedures, and model lists of essential medical devices used

Indicator	Baseline	Target	Achievement
Number of centres in each region offering training in the recommended use of diagnostic imaging	3 centres in 2 regions	1 centre in each region	9 centres in 5 regions
Number of WHO technical programmes that have adopted standard procedures for drawing up a list of essential medical devices	Nil	4 technical programmes	0

Indicator	Baseline	Target	Achievement
Number of WHO thematic lists of devices updated and refined	Nil	4 lists	0

Partly achieved. In May 2007, adoption by the Sixtieth World Health Assembly of the resolution on health technologies, which was the first instrument to address medical devices, led to increased support for work in the area. The resolution was submitted to the Executive Board in May 2006 and the question of including lists of essential medical devices discussed at length. The World Health Assembly urged Member States to collect, verify, update and exchange information on health technologies, in particular medical devices, as an aid to their prioritization of needs and allocation of resources. Experts from Member States concurred that a single list of highest-priority health technologies would be inappropriate. They proposed, instead, that WHO should provide guidance to Member States on a minimum set of health technologies that were necessary for health systems to function and would deliver health care effectively, thus ensuring that the guidance corresponded to needs identified by countries and was appropriate for the context.

Establishment of appropriate components of electronic information for use in health-care systems promoted and effectively supported

Indicator	Baseline	Target	Achievement
Number of countries adopting national policies on use of electronic information in support of health care	6 countries	10 countries	10 additional countries
Number of countries using guidelines for applications of electronic information for health-care delivery	6 countries	10 countries	3 additional countries

Partly achieved. In some African countries, for example Cameroon, Kenya, Mali, Rwanda and South Africa, telemedicine is being used in health care settings. Apart from South Africa, only a few countries have adopted national policies on using electronic information in support of health care. A survey on the status of eHealth in European Member States was conducted and the results published, and a web site on health systems which can be edited collaboratively has been designed for use by WHO technical units. Collaboration is continuing with the Global Observatory for eHealth, the European Commission, the WHO Collaborating Centre for Telemedicine and eHealth, the Healthcare Information and Management Systems Society, the European Space Agency, and the Barcelona Biomedical Research Park. All countries in the South-east Asia Region have prepared national policies on the use of electronic information systems in health. Telemedicine is considered to be useful in countries with difficult terrain, for example Bhutan, Democratic People's Republic of Korea and Maldives, but it is costly to implement and inadequate resources are a major constraint. E-learning is gradually being introduced in many countries in the South-east Asia Region.

Lessons learnt and actions required to improve performance

Lessons learnt:

- The involvement and support of WHO country offices and the presence of country focal points in ministries of health has facilitated implementation of activities and achievement of results. Coordination throughout WHO at the start

of a biennium is essential for more efficient planning and implementation of joint activities. Working in a coordinated manner with other units has improved the effectiveness of support given to countries. Decentralization accompanied by integration of programmes has accelerated implementation of activities.

- The participation of other actors, such as universities and research institutes, in the work of ministries of health has resulted in better, evidence-based decision making.
- Stable and committed national counterparts, supported by health authorities, has led to implementation of agreed products at country level. Progress has been made in improving coordination within WHO, as well as with relevant stakeholders.
- Strong commitment and leadership by governments have been key contributors to much of the progress made in various areas.
- WHO recommendations and guidelines in Russian are increasingly needed for dissemination in eastern Europe.
- The need for integrating health technologies in health systems to meet needs at various levels has been recognized throughout the regions. The technologies are expensive to procure, manage and maintain and, therefore, financial and technical support are required.
- Training trainers initiatives proved to be an effective way of implementing programmes in countries with a large population and/or land area.
- The shift from paid to voluntary and unpaid blood donation catalysed changes in other areas of blood safety and accelerated much needed structural reform in many Member States.

Required actions:

- To establish a designated programme on laboratory strengthening with an integrated and coordinated structure; to build human resource capacity at all levels of the Organization; and to promote joint planning.
- WHO should play a more proactive role in motivating countries to seek assistance in technology assessment before procuring equipment, and in advocating for more and better legislation so that quality and transparency can be assured in organ donation and transplantation. Throughout the regions, there needs to be a guaranteed pool of human resources who possess the appropriate competencies for regulating new technologies. This could be facilitated by establishing links between universities and national regulatory authorities.
- To focus greater attention on health technologies at all levels of health-care systems, from primary to tertiary, since such technologies represent a major investment for Member States, and to provide funding for tools, including guidelines.
- To strengthen communication and collaboration with country offices to further enhance WHO's work at country level. National counterparts should be identified as early as possible to ensure collaboration continues throughout an entire biennium. Coordination of planned activities with WHO collaborating centres should be enhanced to maximize benefits. Inter-programme collaboration between the regions and headquarters should also be further improved. Additional technical and financial resources will be required to increase capacity for responding to country needs.
- To establish effective and efficient coordination and collaboration mechanisms across the Organization to support the development of laboratory services and sustain the momentum already begun in this area by development agencies.
- To improve transparency in the selection and procurement of new technologies and to invest in suitably trained human resources, given that medical technology

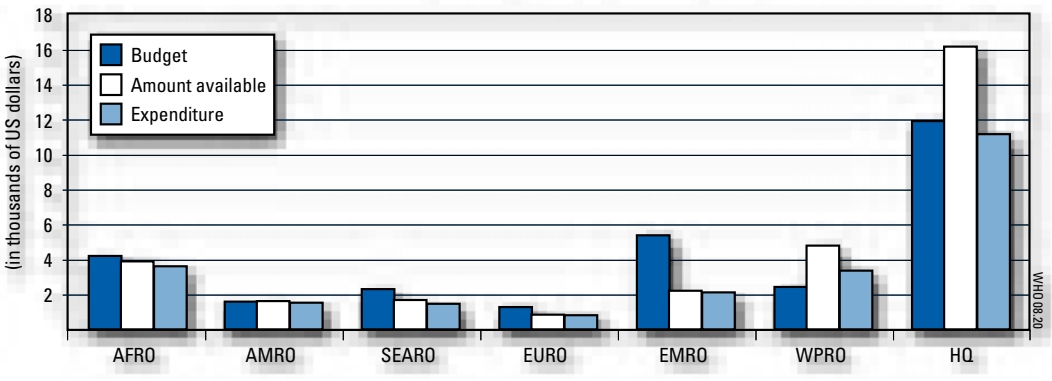
is one of the most costly inputs for health-care systems.

- To establish health technology programmes, as well as trained focal points, in all ministries of health and WHO country offices in order to meet existing challenges.
- To increase advocacy, as well as technical support for planning, assessing and effectively utilizing health technologies through guidelines, norms, standards and assessment tools; to continuously update Member States on evidence-based health technologies; to provide them with technical support for implementing national plans; and to undertake prequalification of priority medical devices and management of information on technologies.
- More resources need to be mobilized to ensure satisfactory outcomes for blood safety programmes in the priority countries, and to guarantee equitable access to safe blood in both urban and rural areas.

FINANCIAL IMPLEMENTATION

Essential health technologies												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	2 647	1 471	4 118	1 960	1 958	3 918	95.1%	1 959	1 604	3 563	90.9%	86.5%
AMRO	577	908	1 485	361	1 277	1 638	110.3%	357	1 099	1 456	88.9%	98.1%
SEARO	1 310	947	2 257	1 171	508	1 679	74.4%	1 171	298	1 469	87.5%	65.1%
EURO	229	1 003	1 232	236	623	860	69.8%	237	576	813	94.6%	66.0%
EMRO	1 802	3 591	5 393	1 797	415	2 213	41.0%	1 797	277	2 074	93.7%	38.5%
WPRO	929	1 439	2 368	1 663	3 076	4 739	200.1%	1 663	1 640	3 303	69.7%	139.5%
Sub-total Regions	**7 494**	**9 359**	**16 853**	**7 190**	**7 858**	**15 048**	**89.3%**	**7 184**	**5 494**	**12 678**	**84.3%**	**75.2%**
HQ	4 645	7 188	11 833	4 463	11 698	16 161	136.6%	4 453	6 683	11 136	68.9%	94.1%
Total	**12 139**	**16 547**	**28 686**	**11 653**	**19 556**	**31 209**	**108.8%**	**11 637**	**12 177**	**23 814**	**76.3%**	**83.0%**

Essential health technologies

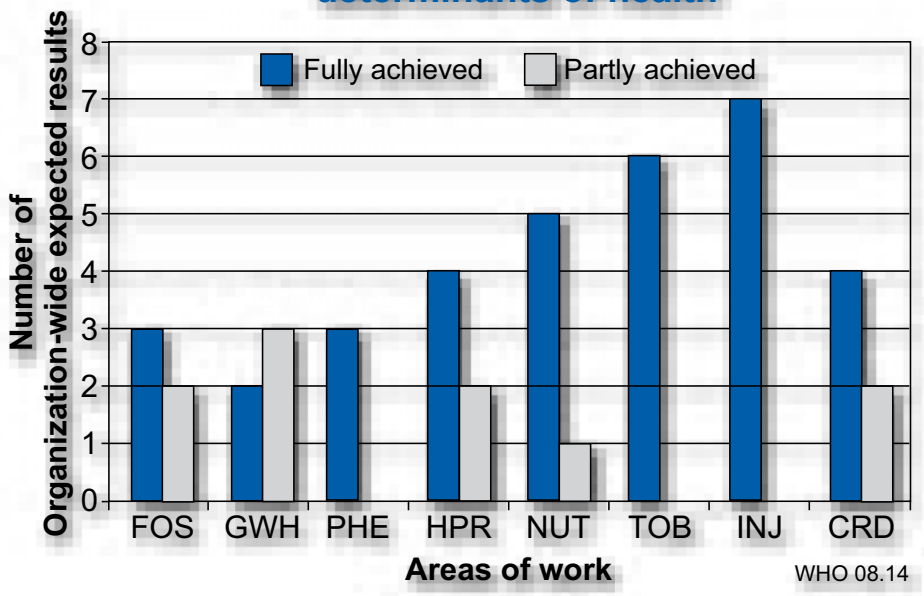


* *Amount available figures are not represented as such in the Financial Report and Audited Financial Statements, but include elements of both income received during 2006-2007 and amounts carried forward from the opening fund balances at 1 January 2006.*

Determinants of health

The Determinants of health grouping comprises the following areas of work: Food safety (FOS); Gender, women and health (GWH); Health and environment (PHE); Health promotion (HPR); Nutrition (NUT); Tobacco (TOB); Violence, injuries and disabilities (INJ); and Communicable disease research (CRD).

Achievement of Organization-wide expected results: determinants of health



Food safety (FOS)

WHO objective(s)

To enable the health sector, in cooperation with other sectors and partners, effectively and promptly to assess, communicate and manage foodborne risks.

Indicator(s) and achievement

- *The increase in the number of countries providing data on foodborne diseases and food hazards, which demonstrates that they are developing a risk-based approach to food safety assessment, management and communication.* At the end of 2007, 78% of Member States were participating in the WHO Global Salmonella Surveillance network to share data on foodborne diseases, and 85% of Member States were participating in the International Food Safety Authorities Network.

Main achievements

- An increasing number of Member States are participating in international networks and providing data on foodborne diseases and food hazards. In all regions, membership of the Global Salmonella Surveillance network has increased. Through the network, national laboratories and institutions are providing data on important foodborne diseases. Sixty-five per cent of countries in the African Region, 100% in the Region of the Americas, 86% in the European Region, 90% in the Eastern Mediterranean Region, 72% in the South-East Asia Region and 55% in the Western Pacific Region now have institutions that are network members.
- Member States are also providing and sharing data through other expanding networks. In the Region of the Americas 29 out of 35 countries (83%) are members of the Inter-American Food Analysis Laboratories Network, while in the European Region, 15 out of 53 countries (28%) have received training in conducting "total diet" studies in order to be able to assess exposure to chemical hazards in the food chain.
- In 2006, WHO implemented the Strategy to Estimate the Global Burden of Foodborne Diseases and established an international expert advisory group. In 2007, the group began the work of providing estimates for all relevant pathogenic and chemical causes by 2011.
- The Codex Trust fund supported the participation of 338 national food-safety experts from 100 countries in 34 Codex Alimentarius Commission meetings.
- An increasing number of Member States are developing a risk-based approach to food safety assessment, management and communication. More than 238 risk assessments were conducted in the area of chemical and microbiological food contaminants as a result of which countries were furnished with timely scientific advice and guidance to better equip them to manage health risks associated with food.

- Dissemination of the "five keys to safer food" in countries has been broadened through different activities in schools, food markets and communities using and adapting the "five keys" manual and poster, which have now been translated into more than 50 languages.
- In September 2007, more than 50 nations adopted the Beijing Declaration on Food Safety. The Declaration urges all countries to develop comprehensive programmes covering all aspects of food production and consumption, including locally produced and imported products and food availability in everyday and emergency situations in order to improve consumer protection.
- The Second WHO European Action Plan for Food and Nutrition Policy 2007–2012, which was adopted by the Regional Committee for Europe at its Fifty-seventh session,[1] emphasizes the importance of countries having a risk-based approach to food safety and of establishing proper surveillance systems for monitoring foodborne hazards in the food chain. The Action Plan also underlines the need for a means of communicating tailored food safety information to the general public and specific subpopulations. The Regional Committee for Africa, at its Fifty-seventh Session, adopted a resolution on food safety and health: a strategy for the WHO African Region,[2] which emphasizes similar aspects. Other regions are taking similar actions.

Achievement of Organization-wide expected results

Foodborne disease surveillance and food-hazard monitoring and response programmes strengthened and international networks established

Indicators	Baselines	Targets	Achievement
Percentage of WHO Member States participating in networks	60%	80%	78% in Global Salmonella Surveillance network and 85% in International Food Safety Authorities Network
Percentage of Member States providing surveillance data to WHO on one or more foodborne diseases, or reporting data from monitoring of microbiological or chemical hazards	34%	At least 50% in each region	40% of WHO Member States reported data on salmonella to the Global Salmonella Surveillance network varying from 13% in the African Region to 68% in the European Region

Partly achieved. Foodborne disease surveillance has been strengthened, mainly through the training and communication activities of WHO's networks, through collaboration with relevant organizations and networks, and through fostering intersectoral collaboration between animal, food and human health professionals. Several regional initiatives in the African, European and Western Pacific Regions have placed emphasis on the importance of foodborne disease surveillance and foodborne hazard monitoring. For example, Asia FoodNet has been established to facilitate the sharing of information on these topics among Asian countries.

[1] Resolution EUR/RC57/R4.
[2] Resolution AFR/RC57/R2.

Timely provision of scientific advice and guidance to developing countries in order to increase their capability to assess risk, and to enable them to participate actively in international risk assessment

Indicators	Baselines	Targets	Achievement
Number of international risk assessments (microbiological and chemical) finalized by WHO and FAO	Estimated 69 international risk assessments conducted in 2004–2005	Double the number of risk assessments	More than 238
Number of participants from developing countries in WHO/FAO expert advisory bodies	Number recorded in 2004–2005	25% increase	12.5% (up from about 10% in 2004–2005)

Partly achieved. As a result of the increased number of international risk assessments carried out, which exceeded the target figure, not only have countries been provided with timely, scientific advice, but more developing countries have also participated in international risk assessment work, which underpins international standard-setting activities. The assessment of the risk associated with *E. sakazakii* in powdered infant formula provides a good example of this timely work. The issue was first raised during the Twenty-sixth session of the Codex Alimentarius Commission and at the Fifty-eighth session of the World Health Assembly. WHO responded by conducting microbiological risk assessments in 2004 and 2006 which became the basis of a new Codex management code of practice and new microbiological criteria. The risk assessments also underpinned WHO's guidelines for the safe preparation, storage and handling of powdered infant formula, which were circulated for comments to 150 Member States before being finalized and translated into several languages. At regional and national level, training and support have been provided to enable Member States to conduct national risk assessment activities and to participate more actively in international standard-setting work, as well as to strengthen the application of risk profiling and risk assessment to food control.

Adequate technical guidance provided to countries to assess and manage the risks and benefits associated with products of new food technologies

Indicators	Baselines	Targets	Achievement
Number of risk assessments, or tools, for risk assessment or management, validated and disseminated by WHO	4 risk assessments of genetically modified foodstuff in developing countries	2 consultations held on risk assessment; one set of guidelines issued	1

Partly achieved. A FAO/WHO consultation on the safety aspects of genetically modified animals was conducted. This was the sole expert consultation in this area required for the period by the Codex Alimentarius Commission. The outcome of this consultation and previous work in the area was disseminated to Member States and reproduced in guidance materials tailored to specific needs.

Effective support provided to countries for the organization and implementation of multisectoral food-safety systems, focusing on health and participation in international standard-setting

Indicators	Baselines	Targets	Achievement
Percentage of countries in each region participating actively in international standard-setting (Codex Alimentarius Commission)	Percentage of countries in each region participating in standard-setting meetings in 2004–2005 122 countries in total participated	At least 60% of countries in all regions participating in standard-setting meetings	Region of the Americas: 60%; African Region: 76%; European Region: 62%; Eastern Mediterranean Region: 77%; South-East Asia Region: 81%; Western Pacific Region: 84%
Number of countries that, with WHO support, have established or amended policies, plans of action, legislation or enforcement strategies for food safety	3 countries per region in 2004–2005	Additional 5 countries per region	Additional countries: Region of the Americas: 11; African Region: 13; European Region: 12; Eastern Mediterranean Region: 10; South-East Asia Region: 4; Western Pacific Region: 7

Fully achieved. In each region, more than 60% of Member States are participating in standard-setting meetings organized by the Codex Alimentarius Commission. The Codex Trust Fund has supported 338 people from 100 countries to attend 34 Codex meetings, thereby broadening participation in its work by Member States. In all regions except one, at least five countries have, with WHO support, formulated or amended policies, plans of action, legislation or enforcement strategies for food safety. In the South-East Asia Region, only four countries have done so, reflecting the fact that it is a relatively small region with fewer Member States. A few countries are working towards establishing a single food-safety authority, but in many others progress in developing food-safety systems is slow and significant capacity building and institutional strengthening is therefore needed. A number of training courses have been conducted to promote national studies and support the preparation of national protocols. These include the Fourth International Workshop on Total Diet Studies and a meeting of the advisory group on the WHO/UNEP coordinated global survey of persistent organic pollutants in human milk.

Adequate support provided to high-priority countries for improving food-safety education, effectively communicating risk, and managing public–private partnerships

Indicators	Baselines	Targets	Achievement
Number of countries that have used and evaluated food-safety material based upon WHO's guidelines for safer food	2 countries per region in 2004–2005	Additional 5 countries per region	Additional countries: Region of the Americas: 6; African Region: 13; European Region: 8; Eastern Mediterranean Region: 10; South-East Asia Region: 10; Western Pacific Region: 8

Fully achieved. In each region, more than the five targeted countries have followed WHO's guidance on safer food based on the "five keys to safer food" approach. The same approach was also disseminated in all regions, utilizing the experience gathered from pilot projects conducted in the previous biennium and which had involved different target groups, including schoolchildren, street food vendors, food handlers and consumers in general. The "five keys" poster has been translated into over 50 languages, while the training manual has been finalized and translated into the six official WHO languages. It is now being translated into additional languages and adapted for different purposes.

Lessons learnt and actions required to improve performance

Lessons learnt

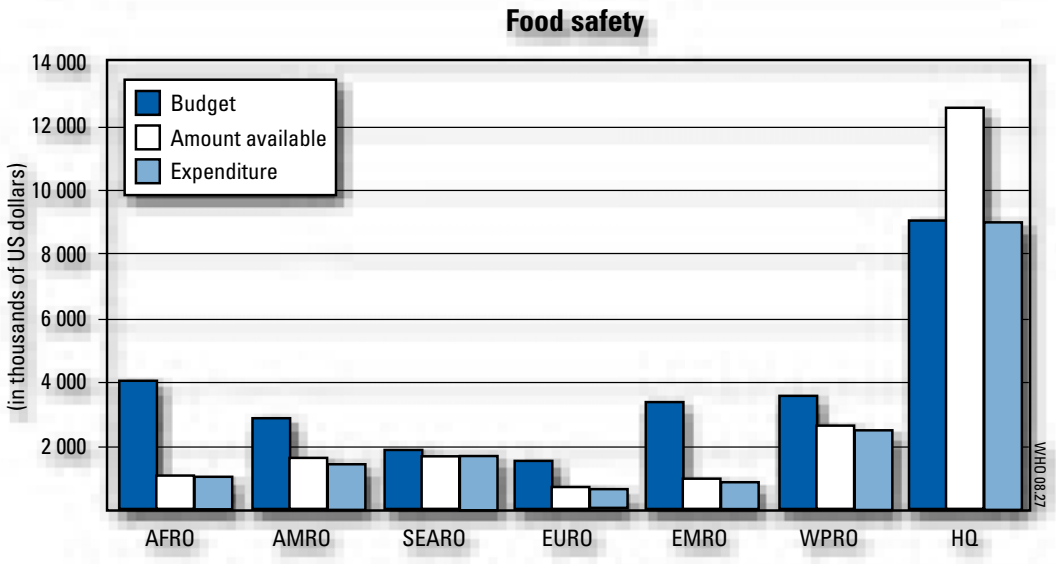
- Forming partnerships with other international agencies and national public health agencies has again proved to be an effective strategy for achieving WHO's objectives.
- Resource mobilization to fund series of activities on similar themes, such as the "five keys to safer food", across different regions should continue.
- The closing of the Pan American Institute for Food Protection and Zoonoses and the downsizing of human resources in December 2005 have seriously affected technical cooperation in food safety in the Region of the Americas.
- There is a need to raise awareness of the public health and societal consequences of foodborne diseases, and to establish holistic and intersectoral food-safety systems with a whole-food-chain approach, including environmental aspects and primary production.
- To achieve a better understanding of the extent of foodborne diseases, work on the global burden of foodborne disease needs to continue; national counterparts should also be given the necessary support to equip them to conduct surveillance and outbreak investigations.
- Food-safety education needs to move beyond advocacy and to identify effective ways of changing behaviour.
- Although several initiatives were undertaken, because they were widely dispersed, consumer participation in raising food standards has remained low in most countries.

Required actions

- To maintain partnerships with other international and regional cooperation agencies for specific technical cooperation programmes and projects.
- To continue to increase competence levels related to the work and procedures of the Codex Alimentarius Commission, as well as support for participation in its meetings.
- To raise awareness of the public health and societal consequences of foodborne diseases and of the need to establish holistic and intersectoral food-safety systems with a whole-food-chain approach, including environmental aspects and primary production, and to sustain that awareness.
- To implement the International Health Regulations (2005) in order to accelerate the process of strengthening national foodborne disease surveillance systems.
- To increase food safety expertise and designated human resources in the regions in order to support the anticipated increase in activities in 2008–2009.
- From the beginning of the 2008–2009 biennium, new institutional arrangements integrating food safety and nutrition should lead to increased cooperation and facilitate joint programming and coordination of activities.
- To strengthen the International Food Safety Authorities Network and the Global Early Warning and Response System in order to make full use of their potential.

FINANCIAL IMPLEMENTATION

Food safety												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	1 595	2 405	4 000	870	191	1 061	26.5%	839	181	1 020	96.2%	25.5%
AMRO	858	1 970	2 828	1 301	295	1 596	56.4%	1 279	101	1 380	86.5%	48.8%
SEARO	564	1 276	1 840	1 424	234	1 659	90.1%	1 424	229	1 653	99.7%	89.8%
EURO	601	899	1 500	466	240	705	47.0%	466	163	629	89.2%	41.9%
EMRO	771	2 561	3 332	646	301	947	28.4%	645	183	828	87.4%	24.8%
WPRO	837	2 663	3 500	1 077	1 564	2 642	75.5%	1 077	1 387	2 464	93.3%	70.4%
Sub-total Regions	**5 226**	**11 774**	**17 000**	**5 783**	**2 826**	**8 609**	**50.6%**	**5 730**	**2 244**	**7 974**	**92.6%**	**46.9%**
HQ	**3 164**	**5 853**	**9 017**	**3 385**	**9 150**	**12 535**	**139.0%**	**3 384**	**5 570**	**8 954**	**71.4%**	**99.3%**
Total	**8 390**	**17 627**	**26 017**	**9 168**	**11 975**	**21 144**	**81.3%**	**9 114**	**7 814**	**16 928**	**80.1%**	**65.1%**



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Gender, women and health (GWH)

WHO objective

To integrate gender considerations into health policies, programmes and research in order to address issues of gender inequality and inequity and alleviate their impact on health.

Indicator(s) and achievement

- *Proportion of Member States and other health partners that are using one or more WHO tools for integrating gender into health policies, strategies and programmes*. 24% of Member States. It was not possible to calculate the proportion of other health partners as the denominator for this calculation is not known.

Main achievements

- The Strategy for integrating gender analysis and action into the work of WHO was adopted by the Sixtieth session of the World Health Assembly.[1]
- Collaborative mechanisms, including annual meetings of the Global Gender, Women and Health Network, electronic consultations and enhanced communications within the Network, were strengthened for more effective joint planning and delivery of technical support for Organization-wide gender mainstreaming activities.
- A full-time gender focal point has been incorporated in WHO and interagency activities are taking place to address sexual and gender-based violence occurring in emergencies.
- Information has been compiled on linkages between gender equality and health in, among other areas, HIV/AIDS, malaria, occupational health, tobacco control, ageing and communicable diseases.
- There has been an increase in the number of partnerships, as well as the level of harmonization, across the Organization for designing methods and tools to scale up gender analysis.

Achievement of Organization-wide expected results

Broader knowledge and evidence on linkages between gender-based issues (including violence) and health, and on successful interventions

Indicator	Baseline	Target	Achievement
Number of technical papers, case studies or reports on gender and health published and disseminated	48	72	87

Fully achieved. Joint planning within the Global Gender, Women and Health Network resulted in the translation of existing papers and reports into other United Nations languages and the development of region-specific materials. Greater emphasis

[1] Resolution WHA60.25.

was placed on disseminating existing and new technical papers, case studies and reports on gender and health in countries. Publication of some documents was carried over from 2004–2005. Collaborative efforts to co-publish materials that serve a dual purpose generates information on the ways in which gender equality affects a broad range of health issues, and leads to more partnerships on gender and health matters inside and outside WHO. Regional offices have focused on disseminating core information through multiple media outlets and events. For example, the Regional Office for the Americas/Pan American Health Organization has issued two key publications[2,3] that have been widely disseminated and have led Belize, Costa Rica and Guatemala to prepare their own brochures. The Regional Office for the Eastern Mediterranean has developed seven gender and health information sheets and a document on cross-cutting gender issues in women's health.[4] The continuing lack of data on the barriers to gender and health measures in many areas hinders the development of new knowledge to inform public health policy and programmes.

Evidence translated into standards and strategies for integrating gender into technical programmes and policies in the health sector

Indicator	Baseline	Target	Achievement
Number of tools and guidelines for integration of gender issues in health policies and intervention	27	48	38
Progress in implementing a strategy on gender and health	A WHO strategy on gender and health formulated	Approval of strategy by Health Assembly	The Sixtieth World Health Assembly adopted the resolution on the strategy for integrating gender analysis and actions into the work of WHO

Partly achieved. Outcomes of regional Global Gender, Women and Health Network meetings included: switching the focus in the preparation of tools and guidelines to completion of the draft tools developed in 2004–2005 and implementation of existing tools and guidelines in regional and country offices. This led to a decrease in the number of tools and guidelines that had originally been included in the target for 2006–2007 and explains why the target was only partly achieved. Progress made in implementing the strategy for integrating gender analysis and actions into the work of WHO is difficult to assess as 2008 is the first year the strategy has been in operation. During the last quarter of 2007, all the regional offices collaborated in the development of a monitoring and evaluation framework. Joint piloting and implementation of new and existing tools and guidelines by headquarters and regional and country offices have ensured that they respond to regional needs and deliver consistent messages on gender and health for dissemination inside and outside the Organization. Intercountry capacity-building workshops on gender mainstreaming in health were held in the African Region, the Region of the Americas, and the Eastern Mediterranean and South-East Asia Regions. They led to an increase in commitment to gender mainstreaming in health as evidenced by the holding of two workshops on the subject in the African Region, six in the Eastern Mediterranean Region and three in the South-East Asia Region. Many regional meetings have been held to discuss the WHO strategy and, as a result, the Regional Office for South-East Asia drafted a set of strategic directions. In addition, the Regional Office for Africa confirmed its Women's Health Strategy and the Regional Office for the Eastern Mediterranean its existing strategic directions. The Pan American Health Organization's Gender Equality Policy was adopted by the 46th Directing Council.[5] Follow-up activities in regions and countries after tools and guidelines have been implemented has been hampered by limited capacity. Human and financial resources, essential for sustainable actions, are both inadequate, and successful long-term outcomes are therefore threatened. A similar lack of resources is curtailing further development of the monitoring and evaluation framework, as well as execution of the baseline assessment of the WHO strategy,

[2] *Gender, health, and development in the Americas: basic indicators 2005.* Washington D.C., Pan American Health Organization, 2005.
[3] *Gender, health, and development in the Americas: basic indicators 2007.* Washington D.C., Pan American Health Organization, 2007.
[4] *Cross-cutting gender issues in women's health in the Eastern Mediterranean Region.* Cairo, World Health Organization, Regional Office for the Eastern Mediterranean, 2007.
[5] Resolution CD46.R16.

which was originally planned for 2007. Despite a high level of commitment during preparation of the WHO strategy and its subsequent submission to the Sixtieth World Health Assembly, there is now a need for greater participation across headquarters and for expressions of firm commitment. If the WHO strategy is to have an impact, technical and financial commitments must be translated into tangible outcomes and accountability mechanisms are therefore needed.

Improved skills and capacities of WHO staff for integrating gender perspectives in their work

Indicator	Baseline	Target	Achievement
Number of WHO programmes receiving technical support such as input into tools, policies, etc.	25	41	45
Number of areas of work integrating gender considerations in their workplans or programme plans	12	33	26
Number of courses, seminars and training activities conducted for WHO staff on gender perspectives	15	33	35

Partly achieved. Since 2004–2005, progress has been made as a result of a concerted effort across the Organization to work more closely with the Global Gender, Women and Health Network on gender and health issues. In 2008–2009, these partnerships will be used to advance the institutionalization of gender mainstreaming. The Regional Office for the Eastern Mediterranean has already made progress in gender and operational planning through the incorporation of a gender module in results-based management training. Despite having limited resources, the Regional Office for South-East Asia has developed collaborative frameworks encompassing 15 areas of work. In the African, European and Western Pacific Regions, progress has been made in working across family and community health departments out of which national programme officers operate. This has undoubtedly increased harmonization across family and community health programmes, as well as ways of addressing gender in these regions. It is expected that in 2008–2009 all the regions will be able to extend their work beyond the confines of family and community health to other clusters.

The number of courses, seminars and training activities on gender perspectives conducted for WHO staff has fallen slightly below the target because priority has been given to responding to country and regional requests for assistance in building capacity for gender mainstreaming in health. Demands for assistance following the inter-regional workshops have restricted capacity-building activities at headquarters. An increase in the number of staff with the requisite expertise should address this gap in 2008–2009. At the same time, an overall shortage of human and financial resources makes it impossible to provide timely responses to all requests for technical support from departments, regions and countries. Adequately resourced gender focal points across technical programmes would facilitate the integration of gender considerations into their work. All the regional offices except the Regional Office for the Americas have only one designated staff member, and country offices often do not have gender focal points at all. Even where they exist, the budget and time allocated for carrying out their work are minimal. Furthermore, a high turnover in gender focal points in health ministries often causes uncertainty in country offices. A revived gender focal point system across the Organization in 2008–2009 would contribute towards sustaining gender mainstreaming activities.

Better public understanding of gender-based issues through a range of advocacy activities and products

Indicator	Baseline	Target	Achievement
Number of international, regional or national events on gender issues	33	53	58
Number of information products produced to increase public understanding of various gender and health issues	20	40	38
Number of global and regional partnerships and networks on gender and health issues	34	48	59

Partly achieved. The Global Gender, Women and Health Network agreed that less emphasis should be placed on developing new information products. Although the focus has changed and is now centred on developing and translating Organization-wide advocacy materials in order to improve public understanding of gender and health issues, progress has been hampered by a shortage of suitably qualified staff, at headquarters and in regional offices, to produce these materials. The appointment of the Director-General's Special Representative on Gender Equality, coupled with widespread support for the strategy for integrating gender analysis and actions into the work of WHO, has enabled the Organization to become more involved in inter-agency, regional and national networks and initiatives on gender health. As a result, it is better placed to increase understanding, influence policy-making, and take the lead in advocating for gender equality in the health sector, although a well-defined strategy for communications and advocacy still needs to be developed. While membership of, and participation in, various gender networks has increased, little time and few resources have been allocated to ensuring they receive sustained technical input. The absence of a Director-General's Special Representative on Gender Equality for most of 2007 because the post was not filled meant that the momentum already generated for gender and women's health could not be maintained.

Greater commitment of Member States to addressing gender-related health policies and strategies

Indicator	Baseline	Target	Achievement
Number of countries (health ministries) integrating a gender perspective in the health sector, supported by WHO	34	47	83

Fully achieved. The extent to which countries are integrating gender in the health sector cannot be assessed as the criteria have yet to be determined. Anecdotal evidence indicates that many countries are beginning to do so, but that full integration of gender perspectives in health-sector activities requires more effort. Headquarters and regional and country offices are working more closely together to ensure that reports, tools and guidelines are guided by country needs, and modifications have been made where necessary, as in the case of two publications on gender mainstreaming in the health sector.[6,7] The absence of, or high turnover in, health ministry gender focal points, and limited regional resources for country support, continue to be obstacles to the provision of good-quality technical assistance in all regions. Strengthening capacity in regional offices would assist them in building on the work carried out during

[6] *Integrating gender into HIV/AIDS programmes in the health sector: guidance to improve responsiveness to women's needs.* Geneva, World Health Organization (forthcoming).
[7] *Gender mainstreaming manual for health managers: a practical approach.* Geneva, World Health Organization (forthcoming).

2006–2007.

Lessons learnt and actions required to improve performance

Lessons learnt

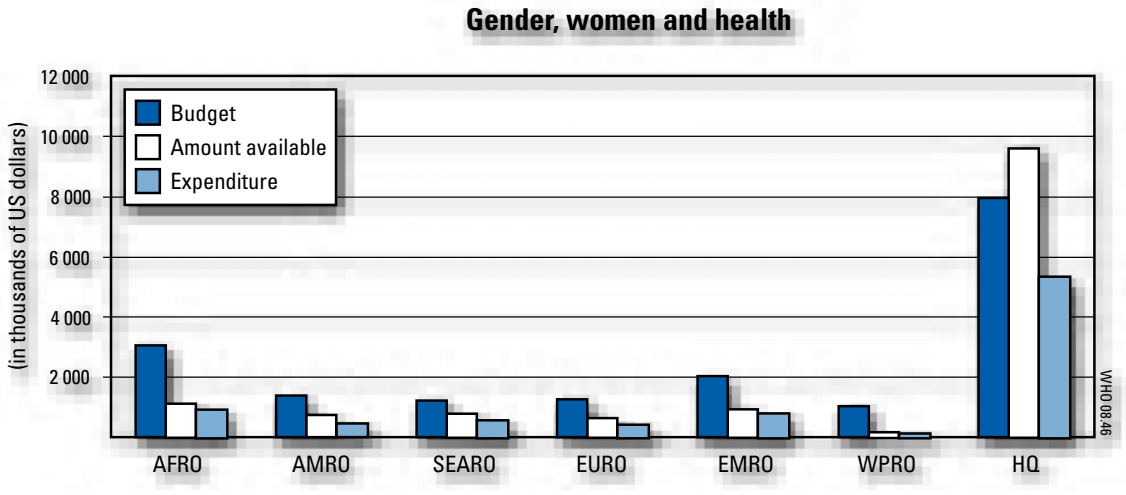
- Joint planning and decision-making within the Global Gender, Women and Health Network is the key to ensuring that activities, messages and products are coherent and delivered in a harmonized way.
- A clear communications and advocacy strategy for WHO and health partners is urgently needed. The misconceptions about gender equality and its role in public health can hinder progress and should be dispelled.
- In addition to building the capacity of individuals, structural mechanisms for establishing gender focal point systems and modifying planning templates to address gender equality are urgently needed.
- While the number of new publications should be limited, there is a need for evidence on the impact of gender mainstreaming in health programmes other than reproductive health. This point has been repeatedly raised in collaborative ventures both inside and outside WHO as information of this sort would also contribute to dispelling misconceptions that such work does not add value in public health.
- A permanent Director at headquarters, and full-time regional advisers and country gender focal points, will enable the Organization to respond to country needs in a timely and harmonized manner. Human resource gaps, particularly in these positions, impedes progress in the integration of gender mainstreaming.

Required actions

- To honour the approved human resource plan, including appointment of a Director early in 2008, in order to ensure that the 2008–2009 workplan can be carried out.
- To prepare and implement a resource mobilization plan for gender mainstreaming across the Global Gender, Women and Health Network.
- To draw up a framework and terms of reference for an Organization-wide gender focal point system in order to scale up the integration of gender mainstreaming.
- To advocate for the appointment of gender focal points in ministries of health to foster collaboration with country office gender focal points.
- To develop and implement a clear communications and advocacy strategy on gender mainstreaming in the health sector for internal and external audiences, which should include the sharing of case studies and forming networks for sharing knowledge on gender and health.
- To increase awareness of the added value of gender mainstreaming in health programmes and policies.

FINANCIAL IMPLEMENTATION

Gender, women and health												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	1 320	1 680	3 000	652	441	1 093	36.4%	652	267	919	84.1%	30.6%
AMRO	433	925	1 358	250	429	680	50.0%	249	127	376	55.3%	27.7%
SEARO	813	373	1 186	471	288	759	64.0%	472	106	578	76.1%	48.7%
EURO	94	1 162	1 256	50	543	593	47.2%	50	339	389	65.6%	31.0%
EMRO	312	1 688	2 000	437	442	879	44.0%	437	296	733	83.4%	36.7%
WPRO	39	961	1 000	2	178	180	18.0%	2	124	126	69.9%	12.6%
Sub-total Regions	**3 011**	**6 789**	**9 800**	**1 863**	**2 321**	**4 184**	**42.7%**	**1 862**	**1 259**	**3 121**	**74.6%**	**31.8%**
HQ	1 362	6 541	7 903	1 310	8 275	9 585	121.3%	1 310	3 965	5 275	55.0%	66.7%
Total	**4 373**	**13 330**	**17 703**	**3 173**	**10 596**	**13 769**	**77.8%**	**3 172**	**5 224**	**8 396**	**61.0%**	**47.4%**



* *Amount available figures are not represented as such in the Financial Report and Audited Financial Statements, but include elements of both income received during 2006-2007 and amounts carried forward from the opening fund balances at 1 January 2006.*

Health and environment (PHE)

WHO objective(s)

To ensure effective incorporation of health dimensions into national policies and action for environment and health, including legal and regulatory frameworks governing management of the human environment, and into regional and global policies affecting health and the environment.

Indicator(s) and achievement

- *Level of commitment to protection of environmental health reflected in policy declarations and development programmes, at national, regional and international levels*. A number of commitments to protecting environmental health have been made both at national and regional level, including the Bangkok Declaration on Environment and Health, issued during the first Ministerial Regional Forum on Environment and Health, held in Bangkok from 8–9 August 2007. In the European Region, the Intergovernmental Midterm Review of the implementation of the Budapest Declaration, held in Vienna from 13–15 June 2007, resulted in a renewed commitment to the Children's Health and Environment Action Plan. Other measures were issue specific, such as the Framework for Action on Drinking Water Quality and Health in Pacific Island Countries, which was endorsed at the Meeting of Ministers of Health of Pacific Island Countries, held in Samoa in March 2005, and various initiatives relating to sanitation, for example the Ministerial Declaration issued at the Latin American Conference on Sanitation, held in Cali, Colombia in November 2007, and endorsement by the United Nations General Assembly of a resolution making 2008 the International Year of Sanitation[1]. In the area of occupational health, the Sixtieth World Health Assembly adopted a resolution on a global plan of action for workers' health[2] and the International Occupational Health Conference, held in Muscat in December 2006, issued the Muscat Declaration on strengthening occupational health. The Fifty-ninth World Health Assembly adopted a resolution on a strategic approach to international chemicals management[3]. In the area of climate change and health, the United Nations Intergovernmental Panel on Climate Change, in its Fourth Assessment Report, identified the serious impact of climate change on human health. The subject was specifically addressed by the Director-General during the Sixtieth World Health Assembly and the Executive Board, at its 122nd session, adopted a resolution on climate change and health[4]. Protecting health from climate change is also the theme of World Health Day 2008 in the year that marks 60 years of WHO's achievements in global public health. A number of international commitments have also been made to address environment and health issues in specific settings, such as the management of health-care wastes and health in the workplace, including silicosis.

Main achievements

- The development and endorsement of the WHO global plan of action on workers' health has triggered a number of regional initiatives and actions in countries to address environment and health issues affecting workers and to establish basic occupational health services.

[1] Resolution A/C.2/61/L.16/Rev.1.
[2] Resolution WHA60/26.
[3] Resolution WHA59/15.
[4] Resolution EB122.R4

- The impact of climate change on health has been gaining attention globally, and as part of United Nations system-wide efforts to combat global warming, WHO was given the task of leading the health agenda.
- A number of key global assessments of the burden of disease were completed and published during the 2006–2007 biennium, such as Preventing disease through healthy environments,[5] which quantified the overall burden of disease attributable to the environment and contained profiles of the environmental burden of disease in 192 countries, as well as some issue-specific assessments, such as the global disease burden from ultraviolet radiation.
- Renewed efforts in the regions to complete national environmental health action plans in countries have resulted in better intersectoral coordination between ministries involved in environment and health risk management. This, in turn, has enabled WHO to strengthen its efforts to build health-sector capacity for working across other sectors of the economy, for example transport and agriculture.
- Regional capacity has been enhanced in various areas, such as drinking water quality management, water safety plans, indoor air pollution, food safety, management of hazardous wastes, integrated management of disease vectors, arsenic mitigation, health care-waste management, occupational health and safety and healthy settings approaches

Achievement of Organization-wide expected results

Evidence-based normative and good-practice guidance developed or updated and promoted that effectively provide support for countries in assessing health impacts and in decision-making across sectors, in key environmental-health areas including water, sanitation and hygiene, air quality, workplace hazards, chemical safety, radiation protection, and environmental change

Indicator	Baseline	Target	Achievement
Number of countries using WHO guidance that have conducted risk assessment and management of key environmental risk factors	18	35	44
Number of countries receiving WHO support that have developed legislation, standards or guidelines related to environmental health	28	40	40

Fully achieved. WHO has continued to lead developments in the application of science to risk assessment and management, for example in risk assessment methodology. Its information products are in great demand, for example a guideline document on drinking-water quality is reported to be the most widely requested WHO publication by Google and the second most downloaded document from the WHO web site. Several key global assessments of the burden of disease were completed and published during 2006–2007, such as Preventing disease through healthy environments,[6] which quantified the overall burden of disease attributable to the environment and contained profiles of the environmental burden of disease in 192 countries, as well as some issue-specific assessments, such as the global disease burden from ultraviolet radiation and the Report of the United Nations Chernobyl Forum.[7] The new WHO air quality guidelines were released and widely promoted through the media and scientific events. They provide policy makers with an authoritative reference from which to develop evidence-based air quality standards and policies. The European Environment and Health Information System, developed with the participation of 18 Member States, 21 institutions, and in collaboration with the European Commission, was launched at the Intergovernmental Midterm Review meeting. The work accomplished

[5] Prüss-Üstün A. and Corvalán C. *Preventing disease through healthy environments. Towards an estimate of the environmental burden of disease.* Geneva, World Health Organization, 2006.
[6] Prüss-Üstün A. and Corvalán C. *Preventing disease through healthy environments. Towards an estimate of the environmental burden of disease.* Geneva, World Health Organization, 2006.
[7] Bennet B. et al., eds. *Health effects of the Chernobyl accident and special health care programmes.* Geneva, World Health Organization, 2006.

during the biennium was largely due to the timely, relevant guidance provided by regional and country offices, increased awareness of environmental and health issues by policy makers, and closer collaboration between health, environment and labour ministries. However, a lack of human and financial resources and limited expertise at country level, as well as internal processes, such as administrative changes at headquarters, all adversely affected the performance of some activities at headquarters and in the regions.

Countries adequately supported in building capacity to manage environmental health information, and to implement intersectoral policies and interventions for protecting health from immediate and longer-term environmental threats

Indicator	Baseline	Target	Achievement
Number of countries implementing action plans on health and environment with WHO's support	40	51	51
Number of countries receiving WHO support that have strengthened health-sector capacity to manage environmental risk factors	15	40	40

Fully achieved. The introduction of several regional and country programmes has led to an increased interest on the part of a number of other countries in implementing similar activities in the next biennium. Intensified cooperation on environment and health risk management and intersectoral policies involving headquarters and regional and country offices have been piloted in China and should be extended to other countries. Cooperation with development banks has been established to promote the health legacy aspects of non-health sector projects which they fund. Assistance from partners, including AusAID, which supported water safety plans in the South-East Asia Region, and the Global Alliance for Vaccines and Immunization, which provided funding for health-care waste management in the African Region, enabled progress to be made in certain areas, despite limited expertise at country level, particularly in economic, legal and policy processes related to risk management, and a lack of human and financial resources.

Environmental health concerns of vulnerable and high-risk population groups (particularly children, workers and the urban poor) addressed by global, regional and country-level initiatives that are implemented through effective partnerships, alliances and networks of centres of excellence

Indicator	Baseline	Target	Achievement
Number of countries that have implemented partnership initiatives to tackle environmental health concerns in relation to children, women and workers	3 countries per region in 2004–2005	Additional 4 countries per region	Additional 14 countries
Number of countries receiving WHO support to accelerate achievement of health- and environment-related regional or international goals	3 countries per region in 2004–2005	Additional 4 countries per region	Additional 4 countries

Fully achieved. A number of international commitments were made to addressing environment and health issues in specific settings, such as the management of health-care wastes and health in the workplace, including silicosis. The Radiation Emergency

Medical Preparedness and Assistance Network now covers 40 centres, and WHO has become more actively involved in networks of international radiation stakeholders. Country-level pilot projects under the WHO–UNEP Health and Environment Linkages Initiative have been completed. New cooperative agreements on chemical safety have been reached with Singapore and Canada, and cooperation with collaborating centres and nongovernmental organizations in official relations with WHO has been intensified. Implementation of the initiatives was facilitated by timely, relevant guidance provided by regional and country offices, increased awareness of environmental and health issues by policy makers, and closer collaboration between health, environment and labour ministries. However, a lack of human and financial resources and limited expertise at country level, as well as internal processes, such as administrative changes at headquarters, all adversely affected the performance of some activities at headquarters and in the regions.

Lessons learnt and actions required to improve performance

Lessons learnt:

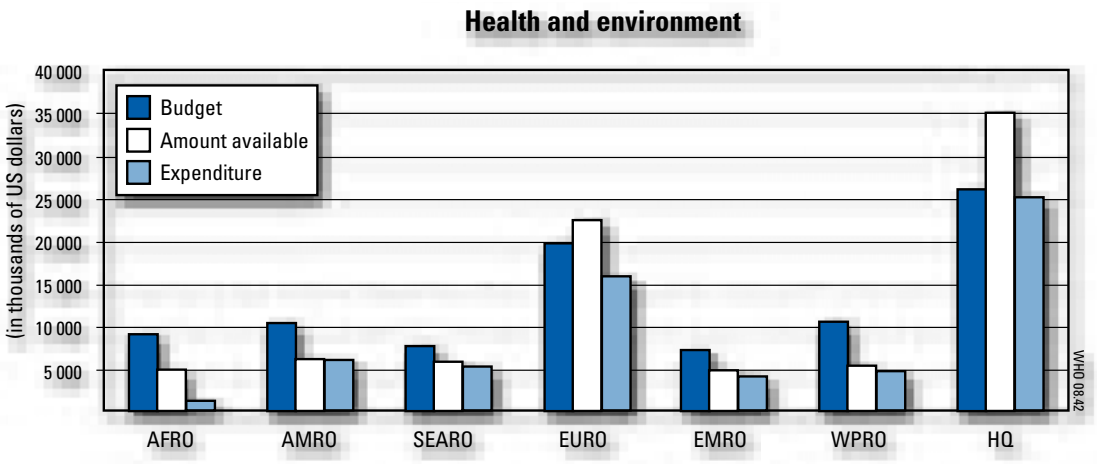
- The level of coordination between headquarters, the regions, country offices and national counterparts can have an influence on overall performance outcomes. Implementation of projects and activities was easier where there was good coordination between the different parts of the Organization. While transitional uncertainties resulting from structural changes at headquarters did not necessarily affect coordination, they may have made it more difficult to implement activities.
- Although the projected targets for the biennium were met, they might have been surpassed and thereby have benefited more Member States, had some of the technical and financial resource constraints been addressed. In future, the allocation of adequate resources should also help to mitigate any adverse effects that competition for limited resources could have on WHO's overall performance.
- Sending clear messages about preventing disease through healthy environments in a targeted way, coupled with a good communication strategy and improved media coverage has proved helpful in moving environmental health issues towards the centre of public health strategies. This was the reason for raising the profile of climate change and health and the current interest in them should be exploited in order to elicit further resources and trigger improvements in environmental health policy and practice.
- Strengthening intersectoral action can improve the effectiveness of targeted environment and health programmes and significantly enhance national risk management capacity. WHO can act as facilitator by supplying technical guidance to assist the health sector in providing strategic direction and leadership, influencing policy in other sectors, for example water, energy, transport and agriculture, and in engaging in strategic partnerships, including with the development banks that fund projects in other sectors.
- Capacity building initiatives, the designation and appointment of national environment and health focal points, and the provision of assistance for the development or revision of national environment and health policies have all resulted in more effective action at country level. Support for national initiatives should be further strengthened in the 2008–2009 biennium, and, in future, should be regarded as a core component of resource mobilization strategies.

Required actions:

- To monitor activities to ensure that WHO's objectives are fulfilled on time.
- To facilitate implementation by strengthening linkages and coordination between headquarters and regional and country offices and by designating environment and health focal points in countries.
- To allocate human and financial resources more equally between technical and normative work on the one hand and country support on the other in order to provide a better service to Member States.
- To develop new partnerships with donors who might be interested in supporting environment and health activities in countries and even in sectors or settings.
- To adjust the resource mobilization strategy to allow activities to be implemented through country work, but in collaboration with the regional offices and headquarters.
- To strengthen coordination and collaboration within headquarters in order to use resources effectively and maximize the impact of WHO's work.

FINANCIAL IMPLEMENTATION

Health and environment												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	6 210	2 790	9 000	4 440	467	4 907	54.5%	797	507	1 304	26.6%	14.5%
AMRO	5 997	4 466	10 463	5 942	195	6 137	58.7%	5 886	82	5 968	97.2%	57.0%
SEARO	4 220	3 313	7 533	4 687	1 110	5 797	77.0%	4 687	641	5 328	91.9%	70.7%
EURO	3 141	16 593	19 734	2 580	19 958	22 538	114.2%	2 579	13 266	15 845	70.3%	80.3%
EMRO	3 665	3 439	7 104	3 532	1 363	4 895	68.9%	3 532	577	4 109	83.9%	57.8%
WPRO	3 757	6 643	10 400	3 466	1 794	5 259	50.6%	3 466	1 285	4 751	90.3%	45.7%
Sub-total Regions	**26 990**	**37 244**	**64 234**	**24 646**	**24 887**	**49 533**	**77.1%**	**20 947**	**16 358**	**37 305**	**75.3%**	**58.1%**
HQ	9 809	16 369	26 178	9 426	25 393	34 819	133.0%	9 418	15 754	25 172	72.3%	96.2%
Total	**36 799**	**53 613**	**90 412**	**34 072**	**50 280**	**84 352**	**93.3%**	**30 365**	**32 112**	**62 477**	**74.1%**	**69.1%**



* *Amount available figures are not represented as such in the Financial Report and Audited Financial Statements, but include elements of both income received during 2006-2007 and amounts carried forward from the opening fund balances at 1 January 2006.*

Health promotion (HPR)

WHO objective(s)

To develop and implement multisectoral public policies for health, integrated gender- and age-sensitive approaches that facilitate community empowerment together with action for health promotion, self-care and health protection throughout the life course in cooperation with the relevant national and international partners.

Indicator(s) and achievement

- *Degree of integration of health promotion into national health strategies and services and appropriate settings*. Since the adoption of the Bangkok Charter for Health Promotion in a Globalized World in 2005, there has been a rapid growth in the number of national health promotion strategies across the regions linked to priority public health concerns, such as ageing, health-promoting settings, oral health, noncommunicable diseases and risk factors. The breadth of application of health promotion concepts demonstrates the relevance of health promotion as a cross-cutting strategy.
- *Sustainability of financing of health promotion interventions in countries*. A range of new structures and financing mechanisms have been introduced in the regions, many of them based on a health promotion foundation model funded by tobacco and alcohol taxation revenue. A start has been made on exploring collaboration with social health insurance schemes in order to encourage them to invest directly in health promotion.
- *Development of a general framework for health promotion strategy*. The elements of a framework have been drawn up. A compendium of health promotion actions has been prepared covering four domains: addressing development and determinants, meeting the needs of individuals and communities, strengthening health systems, and building health promotion capacity. A set of benchmarks for the implementation of the Bangkok Charter are being developed, which should provide a unified framework and capacity-building packages.

Main achievements

- National and regional health promotion strategies have been widely adopted. They connect with an array of vertical health concerns and model health promotion approaches that emphasize equity and upstream interventions.
- Capacity-building exercises in the form of university courses, in-service training courses in countries and ad hoc courses at regional level, have been prioritized in WHO's work with countries. Some of these courses have had a visible impact and, in some cases, led to the setting up of health promotion foundations.
- Some countries, with support, have made progress in securing sustainable financing. However, overall investment in health promotion remains low in many countries, with too few modes of financing.
- Publications on health promotion, its theory and effectiveness have been issued by WHO, but studies by developing countries remain few in number.
- Health promotion in schools and surveillance of the health behaviour of schoolchildren have been important elements in WHO's work. They are increasingly being carried out by countries and regional networks as national counterparts become more self-sufficient.
- Significant developments in the area of health promotion during the biennium included: adoption by the Sixtieth World Health Assembly of resolutions on health promotion in a globalized world,[1] and on an oral health action plan incor-

[1] Resolution WHA60.24.

porating the principles of health promotion and disease prevention and linked to the work being carried out on noncommunicable diseases, in particular shared risk factors and interventions,[2] and the adoption by the Regional Committee for South-East Asia, at its Fifty-ninth session, of a resolution on a regional strategy for health promotion.[3] A global meeting, organized in collaboration with other United Nations bodies, was held in Vancouver, Canada, in June 2007 and a call for action was issued on school health, education and development, which was acted upon in the regions and in collaborative ventures with related United Nations partner agencies.

- In 2007, two parliamentary forums were convened in the Eastern Mediterranean and South-East Asia Regions to promote intersectoral action for health and approaches in health promotion.

Achievement of Organization-wide expected results

Increased guidance for integrating health promotion into health plans, including healthy diet, physical activity, ageing and oral health

Indicator	Baseline	Target	Achievement
Number of countries supported by WHO that have integrated into their health plans strategies for the following: prevention and control of obesity among different age groups, active ageing and oral health	19	25	42

Fully achieved. The Regional Committee for South-East Asia, at its Fifty-ninth session, endorsed the regional strategy for health promotion: follow-up of the Sixth Global Conference on Health Promotion. In the Eastern Mediterranean Region, a regional strategy on health promotion, endorsed by the Regional Committee at its Fifty-second session, was complemented by regional tools for drafting national plans using key elements of the regional strategy. In addition, Thailand, through its work on oral health promotion, and Indonesia, through its work on diet and physical activity, both made progress in integrating health promotion into national noncommunicable disease plans. In the European Region, 26 countries have been actively engaged in a health system project to monitor, review and revise national and subnational health promotion and prevention strategies for children in poverty, Roma health and the health of migrants. Under the auspices of the Healthy Cities programme, 65 cities completed health profiles for vulnerable groups, including older people. The work will be continued in the 2008–2009 biennium. In the African Region, health promotion policies and strategies have been introduced in six new countries, bringing the total to 17 since 2004. These interventions address several underlying determinants of health, such as obesity, oral health and active ageing. In the Eastern Mediterranean Region, eight Member States have developed multisectoral national action plans for health promotion based on the regional health promotion strategy and have integrated these into national health policies. Pakistan has approved a national plan for the control of noncommunicable diseases and health promotion that has a designated budget. Oman is implementing the Global Strategy on Diet and Physical Activity and has established a department in the Ministry of Health for this purpose. Many Member States are considering developing national plans and strategies for health promotion based on the Bangkok Charter. Health promotion is increasingly seen as embodying a cross-cutting approach that should permeate the work of WHO and Member States in public health. However, there is still a perception in some quarters that health promotion deals only with health communication or behavioural change. Furthermore, health promotion in many countries and agencies remains underfunded, or funding is made available only for individual projects. The emphasis on vertical approaches to public health dissociates health promotion from health systems development and can

[2] Resolution WHA60.17.
[3] Resolution SEA/RC59/R4.

lead to avoidable inefficiency as different programmes work to develop distinctive health promotion strategies. The result is often a lack of common understanding and needless competition.

Capacity for governance, stewardship, planning and implementation of multisectoral health promotion policies and programmes strengthened at country and regional levels, based on gender-sensitive approaches to promoting health and well-being throughout the life course

Indicator	Baseline	Target	Achievement
Number of countries that have accurate and updated country profiles on health promotion and risk factors	48	54	78
Number of university public health/ health promotion degree programmes, at national or provincial level in low- and middle-income countries, with strengthened capacity	40	44	57

Fully achieved. University courses in health promotion have been designed or reviewed in several countries, representing an advance in professional training capacity in many lower- and middle-income countries. The Regional Offices for the Eastern Mediterranean and Western Pacific have both begun a new round of Health Promotion Leadership Development and Management (PROLEAD) courses in which five countries in the Eastern Mediterranean Region and 12 in the Western Pacific Region are involved. New capacity-building activities have been launched in the Eastern Mediterranean Region, including a five-day course which has been designed and adopted as the standard format for the Region. In the African Region, capacity-building courses have taken place across the Region. Capacity-building courses with a focus on the needs of socially disadvantaged populations have been organized by the Regional Office for Europe. There is a need for a set of competencies for health promotion that is agreed across WHO as a whole, and that could be stratified by target audience and used to underpin the planning and execution of training programmes, adapted to local needs as necessary. This gap will be addressed in 2008. However, a lack of capacity for expanding training is a more serious problem. Competency in health promotion is an essential resource for health systems. Hence, there is a need for sustainable sources of financing for generating and disseminating programmes to staff working in primary health care, in other health sectors, and in health promotion, who need specially tailored training.

Evidence validated and disseminated of the effectiveness of health promotion strategies and interventions to tackle communicable and noncommunicable diseases

Indicator	Baseline	Target	Achievement
Number of intervention studies demonstrating the effectiveness of health promotion in low- and middle-income countries published in professional journals	5	10	11

Partly achieved. A special issue of the medical journal *Health Promotion International* published several key papers on the Sixth Global Conference on Health Promotion.[1] In the European Region, three publications have attracted political and media attention and have already contributed to policy discussions on health promotion, social determinants and disadvantaged populations in Europe.[2] Obstacles to increasing the number of health promotion publications include limited experience among health

[4] "Sixth Global Conference on Health Promotion, Bangkok August 2005". *Health Promotion International*: Special Issue. Oxford University Press, December 2006, Volume 21, Supplement 1.

[5] Suhrcke, M et al. The contribution of health to the economy in the European Union. Luxembourg, European Communities, 2005. Suhrcke, M et al. Health: a vital investment for economic development in eastern Europe and central Asia. Geneva, World Health Organization, 2007. *Health and economic development in South-Eastern Europe.* Paris, Council of Europe Development Bank and Copenhagen, WHO Regional Office for Europe, 2006. http://tinyurl.com/22t9rm, accessed February 12, 2008.

promotion practitioners in monitoring and evaluating interventions, and the difficulty of gaining access to academic institutions that could support project evaluation and publication of the findings. The limited availability of resources restricts the ability to evaluate field projects with sufficient rigour. Even projects that have a monitoring and evaluation component often encounter other obstacles, for example, over design, that limit their chances of being published in peer-reviewed journals despite being based on sound experience. This area continues to need technical support from WHO, particularly in many lower- and middle-income countries.

New and innovative approaches applied to sustainable financing of health promotion interventions and capacity building at national, local and community levels

Indicator	Baseline	Target	Achievement
Number of health promotion foundations, or other means for financing health promotion, established in countries	6	9	10

Fully achieved. The Regional Office for South-East Asia has completed a review of health promotion financing in the Region and the findings are reported in an internal document. In the African Region, Seychelles has introduced a mechanism whereby tobacco taxes are used by a nongovernmental organization for health promotion. In the Western Pacific Region, three similar mechanisms have been devised based on the concept of a health promotion foundation. A meeting on health promotion foundations: sharing lessons and building capacity, was held in Manila in August 2007. In most countries, increasing pressure is being brought to bear to encourage coordinated action for the mobilization of sustainable financing for health promotion. The momentum in this area will continue during 2008–2009 and will be augmented by work on social health insurance. Collaboration with the International Social Security Association has already led to a session on a joint International Social Security Association/WHO project, to be included in the World Social Security Forum in Moscow in September 2007.[1] Obstacles to more sustainable funding in health promotion include a lack of guidelines, resistance to pricing interventions on tobacco, alcohol and other commodities and the earmarking of revenues derived from such taxes, and a lack of awareness of the benefits that might accrue to social health insurance schemes from investment in health promotion. These issues will form the basis of concerted global action during the period covered by the Medium-term strategic plan 2008–2013.

Global partnership established to provide support to countries in implementing the recommendations of the Sixth Global Conference on Health Promotion, held in Bangkok from 7 to 11 August 2005, and its product, the Bangkok Charter for Health Promotion

Indicator	Baseline	Target	Achievement
Number of country profiles of health-promotion capacity mapped	10	120	The capacity-mapping exercise was concluded in over 120 countries
General framework for effective health promotion strategy developed to tackle risk factors and the underlying determinants	0	1	A meeting of experts was held in London in July 2007 and a draft framework was developed. Further regional consultation is required and the document will be finalized in 2008–2009

Partly achieved. A global meeting hosted by the Regional Office for the Eastern Mediterranean in Oman in September 2006 initiated a process of collaboration in the development of benchmarks for assessing progress on implementation of the Bangkok Charter. These benchmarks will be completed in 2008–2009 and become part of the

[1] World Social Security Forum session on "Coverage gap and chronic disease trends: facing two challenges in a new context". Accessible online at: http://www.issa.int/wssf07/reports/en/b_9.html.

global framework which will guide specific health promotion actions in countries. The majority of countries have taken part in the capacity-mapping exercise, which has established a baseline assessment of the countries involved. The exercise has encouraged all the regional offices to follow up on the findings, build new capacity and repeat the mapping exercise in order to assess progress on a more localized basis. A technical report has been compiled and will be published in 2008. The aim of the global framework for health promotion is to provide evidence-based, country-focused guidance on action for health promotion. Its components were discussed at a meeting of experts in London in July 2007, and a draft framework is now being evaluated. It will be finalized in 2008 and, thereafter, will serve as a guidance document for country collaboration in capacity building and national strategic health promotion planning.

Increased capacity of ministries of health, education and other sectors to plan, implement and evaluate settings-based programmes for reduction of risks associated with leading causes of death, disease and disability

Indicator	Baseline	Target	Achievement
Number of countries that have implemented the Global School-based Student Health Survey, or the survey on Health Behaviour in School-aged Children	46	64	72
Number of countries that demonstrate effectiveness of nationwide school health and HIV prevention training for teachers	16	24	46
Number of functional regional healthy cities networks	3	4	4

Fully achieved. All regions now have projects running and functioning networks on health-promoting settings. These range from health-promoting school activities to healthy city networks. Many countries are now working with their own national networks without WHO support. Education for AIDS (EFAIDS) has been operating in the African Region for 10 years. An estimated 35 countries are now involved and 160 000 teachers have received training in HIV/AIDS education, mostly in Africa. In the Region of the Americas, an Ibero-American technical meeting, held in Brasília in October 2007, used the call for action on school health education and development issued during the meeting in Vancouver, Canada, in June 2007 to justify building strategic alliances between the education and health sectors in order to accelerate progress towards attainment of the relevant Millennium Development Goals. The Regional Office for the Eastern Mediterranean further strengthened its community-based series of local health promotion projects with the underlying premise that improving health is possible only when the community is an active partner in addressing social determinants of health. All countries in the Region now have projects on improved nutritional status, low mortality during disease epidemics, effective malaria and tuberculosis control measures, increased use of safe drinking water, higher school enrolment, and activities to promote healthy lifestyles. In the European Region, the WHO/Health Behaviour in School-Aged Children Forum 2006 on socio-economic determinants of healthy eating habits and physical activity levels was held in Florence, Italy, in March 2006, and the WHO Ministerial Conference for Counteracting Obesity was held in Istanbul, Turkey, in November 2006. Representatives from 17 Member States participated in the forum on social cohesion for mental well-being among adolescents, held in Viareggio, Italy, in October 2007, which provided an opportunity for WHO Representatives to share experiences on promoting the mental well-being of adolescents. At the beginning of January 2007, the technical secretariat of the European Network of Health Promoting Schools was transferred to the Netherlands Institute of Health Promotion and Disease Prevention. In the South-East Asia Region, training on health

behaviour in school-aged children was conducted in 9 countries, eight of which are now designing their own programmes. In the Western Pacific Region, the Alliance for Healthy Cities comprises 62 member cities and operates as an independent network with WHO acting as an advisor. Fifteen Pacific Island countries have received training in health behaviour in school-aged children.

Lessons learnt and actions required to improve performance

Lessons learnt

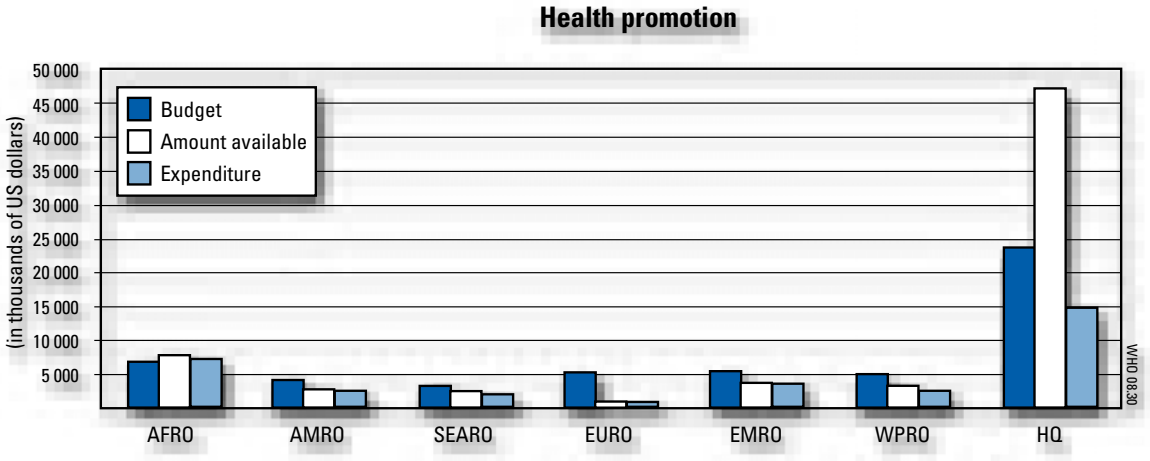
- Health Promotion is an effective public health strategy for addressing social determinants of health. Since the adoption of the Bangkok Charter, its role has been strengthened and its potential recognized by policy makers.
- There is strong demand for capacity building in health promotion and the regional offices are responding to these requests with a range of robust models for curricula and courses. However, the need is still largely unmet even though health promotion has existed as a strategy for over two decades.
- Some aspects of health promotion, such as health-promoting settings, schools and workplaces, are increasingly becoming independent areas of operation in countries. However, there are growing indications that other areas require technical support, for example, action on determinants of health, multisectoral action and partnerships for health promotion.

Required actions

- To strengthen the capacity of developing countries in measuring the effectiveness of their projects. More investment is needed so that the impact of projects on policy and behaviour, as well as the relevance of gender, can be demonstrated to a greater extent than was possible in 2008–2009.
- To extend the range of financing mechanisms for health promotion and to ascertain the sustainability of funding in countries.
- To strengthen intersectoral work and create mutually beneficial partnerships for health promotion that are properly institutionalized within both WHO and Member States.
- In order to continue to build capacity for implementing health-promotion projects in Member States, health system development approaches, as well as primary care strategies, need to integrate this concern and respond to it.

Financial implementation

Health promotion												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	5 169	1 429	6 598	6 476	1 151	7 628	115.6%	6 456	836	7 292	95.6%	110.5%
AMRO	2 225	1 939	4 164	2 227	549	2 776	66.7%	2 171	458	2 629	94.7%	63.1%
SEARO	1 949	1 015	2 964	1 769	814	2 583	87.2%	1 769	130	1 899	73.5%	64.1%
EURO	207	4 928	5 135	64	976	1 039	20.2%	63	734	797	76.7%	15.5%
EMRO	2 675	2 591	5 266	3 192	529	3 721	70.7%	3 193	372	3 565	95.8%	67.7%
WPRO	1 226	3 654	4 880	1 608	1 698	3 306	67.8%	1 608	943	2 551	77.2%	52.3%
Sub-total Regions	**13 451**	**15 556**	**29 007**	**15 336**	**5 717**	**21 054**	**72.6%**	**15 260**	**3 473**	**18 733**	**89.0%**	**64.6%**
HQ	1 126	22 514	23 640	2 281	44 772	47 053	199.0%	2 228	12 382	14 610	31.1%	61.8%
Total	14 577	38 070	52 647	17 617	50 489	68 106	129.4%	17 488	15 855	33 343	49.0%	63.3%



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NUTRITION (NUT)

WHO objective(s)

To promote healthy diets and optimal nutrition of people throughout the life course, particularly women and children, through the implementation, monitoring and evaluation of national policies and programmes.

Indicator(s) and achievement

- *Number of countries with effective policies and programmes to control malnutrition.* Policies and programmes to control malnutrition at differing levels of development and implementation are in place in 101 countries.
- *Number of countries that have made progress towards the Millennium Development Goals related to nutrition.* At least 59 countries.

Main achievements

- The WHO Child Growth Standards were launched in April 2006. Progress in their dissemination throughout the world has been stimulated by regional capacity-building efforts and 83 countries are already implementing the Standards.
- In 2006, the WHO/WFP/FAO guidelines on food fortification with micronutrients covering both the public health and technological aspects of fortification were issued. Their main purpose is to assist countries in the design and implementation of appropriate food fortification programmes.
- Publication of the WHO/United Nations Standing Committee on Nutrition/UNICEF Joint Statement on Community-based Management of Severe Acute Malnutrition should have an impact on child mortality.
- The launching in October 2007 of the landscape analysis on countries' readiness to act in nutrition in 36 high-burden countries facilitates the identification of opportunities for integrating new and existing effective nutrition actions that will allow countries' readiness to act at scale in nutrition to be assessed.

Achievement of Organization-wide expected results

New WHO growth standards implemented and global, regional and national nutrition surveillance systems strengthened

Indicator	Baseline	Target	Achievement
Number of countries that have initiated implementation of WHO's new growth standards	0	20	73
Number of countries covered by global integrated nutrition database with comprehensive nutritional profiles including major forms of malnutrition	79	99	127

Fully achieved. Training and support have been provided to countries to assist them in developing plans for implementing the new WHO Child Growth Standards. Many countries are contributing data on nutritional profiles which is entered in the nutrition databases and used for global analyses, such as The Lancet Series on Maternal and Child Undernutrition.

Integrated national food and nutrition policies and plans developed or integrated and promoted in order to meet nutrition needs throughout the life course and to tackle nutritional transition

Indicator	Baseline	Target	Achievement
Number of countries receiving WHO support that have revised, updated and/or developed integrated nutrition policies and plans	5	15	37

Fully achieved. National capacity-building training courses in developing and implementing integrated national nutrition plans and policies were held in the Eastern Mediterranean, South-East Asia and Western Pacific Regions and contributed towards strengthening national nutrition policies and strategies in 24 priority countries. Technical and financial support was provided to many Member States to assist them in adapting both the Global Strategy on Infant and Young Child Feeding and the Global Strategy on Diet, Physical Activity and Health to meet national needs.

Technical and policy support provided for the implementation of integrated strategies to improve maternal and child health and nutrition, including managing severe malnutrition, promoting fetal development, and ensuring adequate child growth, optimal breastfeeding and complementary feeding practices

Indicator	Baseline	Target	Achievement
Number of countries using or adapting WHO guidelines on management of severe malnutrition	30	40	42
Number of guidelines and recommendations finalized on integrated and multisectoral approach to optimizing fetal development	0	1	2
Number of countries that have implemented at least 3 high-priority actions defined by WHO's global strategy for infant and young child feeding for protection, promotion and support, as appropriate	30	60	106

Fully achieved. Support was given to a number of countries to enable them to adapt and use the WHO guidelines on the management of severe malnutrition. Several countries have developed national protocols on the management of severe malnutrition. Countries from all six regions participated in a consultation to review a draft global framework for promoting optimal fetal development. Many countries have implemented a significant number of the nine operational targets of the Global Strategy for Infant and Young Child Feeding, particularly those relating to exclusive breastfeeding, appropriate complementary feeding and giving effect to the International code of Marketing of Breast-milk Substitutes.

Technical and policy support provided to promote healthy diets, including the revision of food-based dietary guidelines, and to reduce obesity and other nutrition-related noncommunicable diseases in the context of the nutritional transition and the dual burden of deficiencies and diseases related to under- and over-nutrition

Indicator	Baseline	Target	Achievement
Number of countries receiving WHO support that have revised, updated and/or developed food-based dietary guidelines	0	5	34
Number of countries receiving WHO support that have implemented activities to promote healthy diets, with emphasis on increasing fruit and vegetable consumption	0	10	37
Number of WHO guidelines available on control of obesity, with emphasis on childhood obesity	0	2	2

Fully achieved. A review of national food-based dietary guidelines was undertaken in the Region of the Americas and the Eastern Mediterranean and Western Pacific Regions, and an assessment of the scientific evidence for developing regional food-based dietary guidelines in the Eastern Mediterranean Region resulted in a set of draft regional guidelines being produced.

The framework of the nutrition-friendly schools initiative, which provides approaches and measures for addressing the growing dual burden of child undernutrition and overweight and obesity, was developed in consultation with partner agencies and concerned key stakeholders. The framework was pilot-tested in several countries and, in the European Region in particular, was identified as a policy tool that would assist Member States to implement the second food and nutrition action plan, adopted by the Regional Committee in September 2007.

A training module on effective communication strategies to improve national nutrition programmes has been disseminated to some Member States and collaboration with UNICEF is continuing to effect its introduction in others. A scientific update on carbohydrates in human nutrition was undertaken jointly with FAO, providing further evidence of the role of nutrition in preventing major nutrition-related chronic diseases, namely obesity, diabetes, cardiovascular disease and cancer.

Innovative ways of supplementation and optimal food-fortification programmes with micronutrients of public health significance promoted to improve micronutrient status of populations

Indicator	Baseline	Target	Achievement
Number of countries with national programmes on micronutrient-deficiency control assessed by WHO	4	6	16
Number of countries that have implemented WHO guidelines on micronutrients	5	10	79

Fully achieved. Many countries are covered by the Vitamin and Mineral Nutrition Information System and have implemented guidelines on controlling anaemia and iodine and vitamin A deficiencies through fortification and supplementation.

Technical and policy support provided to improve nutrition in crises and in special circumstances, including people living with HIV/AIDS

Indicator	Baseline	Target	Achievement
Number of countries receiving WHO support that have developed and implemented action plans on nutrition and HIV/AIDS	3	35	32
Number of updated or revised WHO guidelines available on nutrition action in emergencies and post-emergencies	4	6	11

Partly achieved. A number of countries received support to develop and implement action plans on nutrition and HIV/AIDS. Some countries have developed comprehensive strategies on infant feeding in the context of HIV. Recommendations and counselling on breastfeeding practices are being included among health practices in some countries. A regional consultation on nutrition and HIV/AIDS was held in Bangkok from 8 to 11 October 2007 to find concrete solutions to the twin epidemics of HIV/AIDS and malnutrition in the South-East Asia Region. A participants' statement was issued to mark the commitment of countries in the Region, with defined obligations, specific goals and solid actions. A draft revised training tool for the management of severe malnutrition, and policy guidelines on the integrated management of severe malnutrition, are now available.

A WHO/Global Fund to Fight AIDS, Tuberculosis and Malaria meeting was held in Harare from 17 to 20 April 2007 for the purpose of ensuring that nutritional care and support is one of the essential elements of the response to the epidemic. Few countries succeeded in having nutrition included in Round 7 of the Global Fund. At a regional consultation held from 2 to 4 May 2007 in Nairobi in order to assess countries' progress in implementing the recommendations of the 2005 Durban consultation on nutrition and HIV/AIDS, it emerged that advances have been made in developing national policies, strengthening human capacity and preparing materials in this crucial area. A WHO/UNICEF regional consultation on breastfeeding protection, promotion and support, held in Manila from 20 to 22 June 2007 to encourage countries to renew their commitment to the infant feeding recommendations contained in the global child survival strategies, was attended by representatives from 70 Member States.

Lessons learnt and actions required to improve performance

Lessons learnt

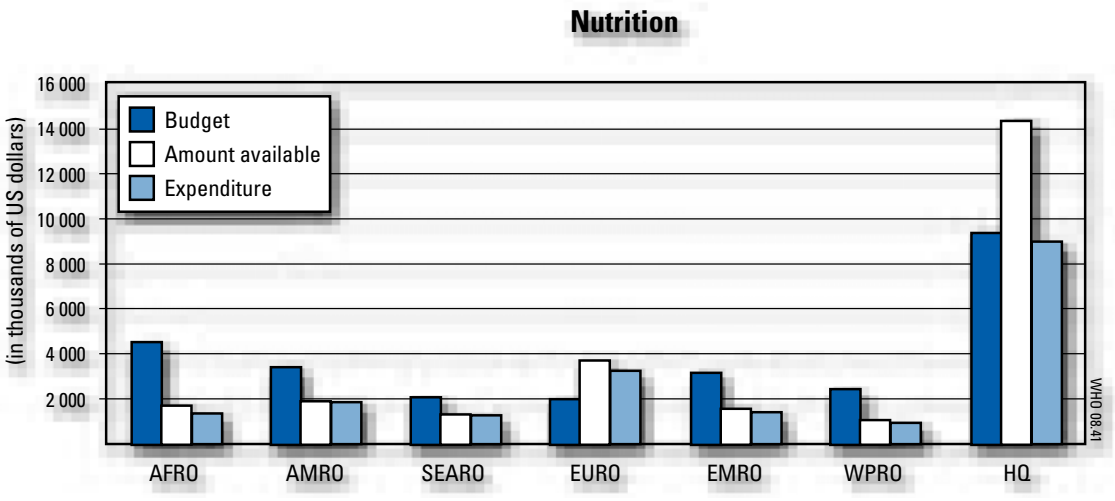
- Several Member States require assistance in order to attain the Millennium Development Goals, particularly through interventions that have a direct bearing on hunger, food insecurity and malnutrition.
- The availability of data on the prevalence of different nutrition disorders and progress achieved through interventions is crucial and an upgrading of the current databases is therefore required.
- Information sharing among national counterparts in Member States must be enhanced, particularly in relation to the planning of intercountry activities.
- An analysis of the situation in several countries with the greatest malnutrition burden has been initiated with significant support from countries.

Required actions

- More emphasis needs to be placed on activities related to attainment of the Millennium Development Goals.
- More active promotion of WHO guidelines and standard protocols will facilitate intercountry and intracountry comparison of interventions.
- The proposals contained in The Lancet Series on Maternal and Child Undernutrition for improving use of the new nutritional action tools need to be followed up.
- The ongoing landscape analysis on readiness to act in nutrition needs to be followed up.
- Collaborative efforts with other relevant agencies are urgently required to develop standardized systems for the provision of scientific advice on nutrition.
- The potential for a significant increase in activities at country level as a result of a renewed focus on improving nutrition, food safety and food security, throughout the life course, and in support of public health and sustainable development will require more designated staff in regional and country offices.
- A necessary prerequisite for significantly increasing activities at country level is the presence of more longer-term staff at headquarters. The budgetary split inhibits such action and strategic decisions to rectify the situation are urgently needed.

Financial implementation

Nutrition												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	2 589	1 911	4 500	799	890	1 689	37.5%	797	507	1 304	77.2%	29.0%
AMRO	1 192	2 170	3 362	1 173	669	1 842	54.8%	1 166	584	1 750	95.0%	52.1%
SEARO	1 109	891	2 000	1 019	317	1 336	66.8%	1 019	229	1 248	93.4%	62.4%
EURO	609	1 291	1 900	891	2 798	3 688	194.1%	891	2 304	3 195	86.6%	168.2%
EMRO	588	2 483	3 071	659	891	1 550	50.5%	659	703	1 362	87.9%	44.4%
WPRO	489	1 861	2 350	511	521	1 032	43.9%	511	360	871	84.4%	37.1%
Sub-total Regions	**6 576**	**10 607**	**17 183**	**5 051**	**6 086**	**11 137**	**64.8%**	**5 043**	**4 687**	**9 730**	**87.4%**	**56.6%**
HQ	2 855	6 470	9 325	2 744	11 568	14 312	153.5%	2 744	6 163	8 907	62.2%	95.5%
Total	**9 431**	**17 077**	**26 508**	**7 795**	**17 654**	**25 450**	**96.0%**	**7 787**	**10 850**	**18 637**	**73.2%**	**70.3%**



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TOBACCO (TOB)

WHO objective(s)

To reduce continuously and substantially both tobacco use and exposure to tobacco smoke, by putting in place effective tobacco-control measures and providing support to Member States in implementing the WHO Framework Convention on Tobacco Control.

Indicator(s) and achievement

- *Number of countries that are Parties to the Framework Convention*. As a result of WHO's awareness-raising efforts, 151 Member States are now Parties to the Framework Convention.
- *Number of countries with effective tobacco-control policies and plans that take account of the provisions of the Framework Convention.* Sixteen countries have a comprehensive ban on smoking in at least eight locations without any exceptions, for example, hospitals, schools, universities, government offices, indoor workplaces, restaurants, bars and other indoor places. An additional 35 countries have a complete ban in health-care and educational facilities, as well as in at least three other settings. In 55 countries, the taxable proportion of the price of a packet of cigarettes is between 50% and 75%, and in four additional countries it exceeds 75%. Twenty countries meet the Framework Convention advertising ban standard, and 41 meet its criteria for health warnings on cigarette packets, including the ban on deceitful terms such as "light" or "ultra light". It is estimated that 86 countries meet the Framework Convention standard to "establish progressively a national system for the epidemiological surveillance of tobacco consumption".

Main achievements

- The number of Parties to the Framework Convention has increased rapidly and a permanent Convention Secretariat has been established.
- Cost-effective tobacco control policies were implemented in a significant number of Member States.
- WHO policy recommendations on key tobacco control policies were prepared.
- A surveillance system covering the majority of Member States was developed.
- Data collection for the WHO Report on the Global Tobacco Epidemic, 2008 provided valuable information for tobacco control monitoring.

Achievement of Organization-wide expected results

Advocacy and provision of support for ratifying, accepting, approving, formally confirming or acceding to the Framework Convention

Indicator	Baseline	Target	Achievement
Number of Member States that are Parties to the Framework Convention	40	70	151

Fully achieved. Close collaboration between headquarters and regions resulted in 151 Member States becoming Parties to the Framework Convention. Subregional awareness-raising workshops were held in an effort to increase the number of Contracting Parties.

Support provided for reflecting the provisions of the Framework Convention in national tobacco-control policies and plans of action

Indicator	Baseline	Target	Achievement
Number of countries that have adopted legislation or its equivalent in relation to at least one of the following settings and articles: smoking bans in health-care and educational facilities, bans on direct advertising of tobacco products in national media, health warnings on tobacco products that meet the criteria set out in the Framework Convention, and the inclusion of tobacco-use cessation in national health-care programmes	40	80	95
Number of tobacco-control success stories, and lessons learnt, published and disseminated by WHO	35	50	56

Fully achieved. The targets were exceeded as a result of the support given to countries by WHO to strengthen their tobacco control measures. Legislation, or its equivalent, has been adopted in 95 countries to allow smoking bans to be imposed in health-care and educational facilities. Ninety-two countries have banned direct advertising of tobacco products in national media. Health warnings that meet the criteria in the Framework Convention appear on tobacco products in 46 countries, and in 20 countries cessation activities are included in national health-care programmes.

Support provided for reinforcing capacity for surveillance and research to back up tobacco control in the areas of health, economics, legislation, environment and behaviour

Indicator	Baseline	Target	Achievement
Number of countries that have completed the Global Youth Tobacco Survey at least twice	40	80	77 countries and 4 territories
Number of countries covered by a global information system on tobacco control	60	120	179 and one territory
Number of economic and intervention-based research studies supported by WHO	12	20	22 (of which 2 are ongoing)

Fully achieved. In partnership with the Centers for Disease Control and Prevention, 81 Member States and territories completed the Global Youth Tobacco Survey at least twice. With financial support from the Bloomberg Initiative, WHO has collected data on tobacco use and the status of tobacco control interventions in 179 Member States and one territory, and has produced the first comprehensive analysis of global tobacco control. For the second report, work is in progress with the donor, regions and experts to harmonize the methodology of data collection and analysis at country level in order to make available comparable trend information across countries and over time. A number of studies on tobacco growing, up to now a somewhat neglected subject, have also been prepared.

The most important economic and intervention-based research studies supported by WHO were on tobacco cultivation and poverty in Bangladesh, tobacco and alternative crops in India, the impact of tobacco-related illnesses in Bangladesh, the implications of the South Asia Free Trade Agreement on the tobacco trade, family farmers and

diversification strategies in Brazil, poverty in Bolivia, tobacco growing in the European Union, tobacco cultivation and possible alternative crops in Kenya, tobacco and poverty in the African Region, and an overview of existing work on crop substitution and alternative crops for tobacco.

Advocacy and provision of support for raising awareness both of the dangers of tobacco, through strong media coverage and comprehensive information on web site, and of tobacco-industry activities

Indicator	Baseline	Target	Achievement
Number of countries that celebrate World No Tobacco Day	60	80	105
Average number of web site hits per month	400 000	500 000	950 000
Number of published results of country-specific research on tobacco-industry activities	20	25	31

Fully achieved. In 2007, the focus of World No Tobacco Day was on 100% smoke-free environments. The campaign highlighted the progress made in recent years by countries, cities and communities in enacting smoke-free policies and legislation and encouraged more countries to implement smoke-free policies and legislation. The published results of country-specific research on tobacco-industry activities included country reports from Brazil, China, Germany, Kenya, Malawi, the Russian Federation, Thailand and Uzbekistan, regional reports from the Regional Offices for Europe and the Western Pacific, and, at global level, from the United States Department of Justice.

Knowledge of tobacco-product regulation improved in order to guide policy developments

Indicator	Baseline	Target	Achievement
Number of recommendations published by the WHO Study Group on Tobacco Product Regulation	8	10	12

Fully achieved. The WHO Study Group on Tobacco Product Regulation published a technical report on tobacco product regulation, which contained four additional recommendations on: the contents and design features of tobacco products and their relationship to dependence and consumer appeal; the research needs arising from and regulatory recommendations for candy-flavoured tobacco products; biomarkers of tobacco exposure and tobacco smoke-induced health effects; and setting maximum limits for toxic constituents in cigarette smoke.[1] These recommendations have been distributed to Member States to assist them in drafting regulatory frameworks.

Multisectoral collaboration on tobacco control increased through advocacy

Indicator	Baseline	Target	Achievement
Number of new projects initiated under the umbrella of the United Nations Ad Hoc Inter-Agency Task Force on Tobacco Control	9	12	13
Worldwide membership of GLOBALink	4500	5500	6100

[1] *The scientific basic of tobacco product regulation: report of a WHO study group.* Geneva, World Health Organization Technical Report Series 945, 2007.

Fully achieved. The work carried out by the United Nations Ad Hoc Inter-Agency Task Force led to the adoption in 2006 of a United Nations Economic and Social Council resolution on smoke-free United Nations premises.[2] The next challenge will be to secure the adoption of a similar resolution by the United Nations General Assembly. The increase in GLOBALink membership worldwide is partly due to the support given by WHO to language-specific discussion lists, notably in Russian, Arabic and Portuguese. Three other new projects were initiated, namely, the drafting of the fourth report of the Secretary-General to the United Nations Economic and Social Council, the inclusion of tobacco among the health indicators of the United Nations Commission on Sustainable Development Indicators of Sustainable Development, and the organization of an intercountry meeting on tobacco control, poverty reduction and the Millennium Development Goals in Dhaka in August 2007.

Lessons learnt and actions required to improve performance

Lessons learnt

- Good communication between headquarters, regions and countries, as well as partners, is a key element in increasing the Framework Convention's visibility and is helpful for resource mobilization.
- The availability of data on the prevalence and socioeconomic impact of tobacco use is a strong advocacy tool.
- The allocation of funds from national budgets is the key to tobacco control implementation.
- The scaling up of staff numbers at national and regional levels is facilitating the implementation of global programmes.
- At country level, when using the services of local consultants it is important to have a rigorous selection process in order to ensure that the best-quality work is delivered in a timely manner.
- WHO's leadership role in tobacco control is becoming increasingly recognized.

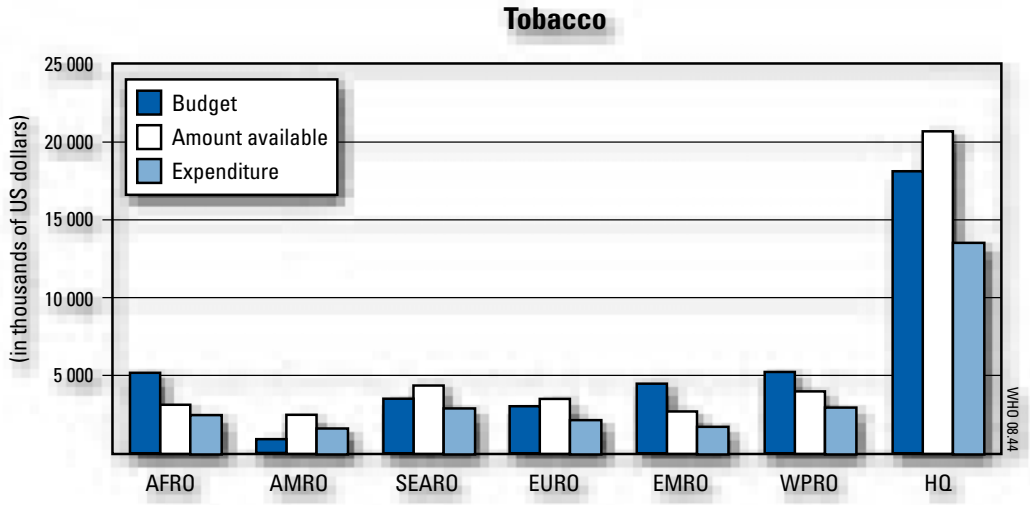
Required actions

- To strengthen advocacy and provide more support to enable countries to ratify or accede to the Framework Convention.
- To build capacity at country level to enable countries to implement the provisions contained in the Framework Convention.
- To strengthen advocacy for mobilization of non-earmarked funds to allow the normative, awareness-raising and capacity-building work to continue.
- To continue data gathering, surveillance and monitoring activities.
- To begin gathering gender- and age-disaggregated data.
- To gather more economics-related data for analysing the economic impact of tobacco consumption and tobacco control. There is a need for more detailed data on taxes and revenues, as well as on tobacco consumption (smoked and smokeless).
- To maintain and maximize the synergy and complementarity between headquarters and the Convention Secretariat.

[2] Resolution 2006/42.

Financial implementation

Tobacco												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	3 113	1 887	5 000	1 494	1 620	3 115	62.3%	1 495	943	2 438	78.3%	48.8%
AMRO	698	290	988	223	2 169	2 392	242.1%	216	1 385	1 601	66.9%	162.0%
SEARO	2 193	1 237	3 430	1 571	2 722	4 293	125.2%	1 571	1 308	2 879	67.1%	83.9%
EURO	752	2 248	3 000	587	2 784	3 371	112.4%	587	1 511	2 098	62.2%	69.9%
EMRO	1 665	2 699	4 364	697	1 910	2 606	59.7%	697	937	1 634	62.7%	37.4%
WPRO	1 957	3 243	5 200	1 353	2 542	3 895	74.9%	1 353	1 507	2 860	73.4%	55.0%
Sub-total Regions	**10 378**	**11 604**	**21 982**	**5 926**	**13 746**	**19 672**	**89.5%**	**5 919**	**7 591**	**13 510**	**68.7%**	**61.5%**
HQ	3 478	14 610	18 088	4 956	15 689	20 645	114.1%	4 951	8 445	13 396	64.9%	74.1%
Total	**13 856**	**26 214**	**40 070**	**10 882**	**29 435**	**40 317**	**100.6%**	**10 870**	**16 036**	**26 906**	**66.7%**	**67.1%**



* *Amount available figures are not represented as such in the Financial Report and Audited Financial Statements, but include elements of both income received during 2006-2007 and amounts carried forward from the opening fund balances at 1 January 2006.*

VIOLENCE, INJURIES AND DISABILITIES (INJ)

WHO objective(s)

To formulate and implement cost-effective, age- and gender-specific strategies to prevent and mitigate the consequences of violence and unintentional injuries, and disabilities, and to promote and strengthen rehabilitation services.

Indicator(s) and achievement

- *Number of countries that formulated policies and prevention programmes on violence and injuries.* Eighty-nine countries have either formulated policies and prevention programmes on violence and injuries or are in the process of eliciting support from WHO in order to do so.
- *Number of countries that formulated policies on disabilities and implemented plans for strengthening rehabilitation services.* Forty-nine countries have formulated policies on disabilities and implemented plans for strengthening rehabilitation services.

Main achievements

- A number of important partnerships have been created or reinforced at global, regional and national levels. These include: global and regional networks of ministry of health focal persons for injury and violence prevention, the United Nations Road Safety Collaboration and the Violence Prevention Alliance, and partnerships with one or several United Nations agencies and other entities for the purpose of preparing documents and providing support to countries.
- The first United Nations Global Road Safety Week dedicated to youth was celebrated in most countries and youth leaders from 100 countries attended the World Youth Assembly.
- A number of normative documents were published, including *Preventing injuries and violence: a guide for ministries of health*[1] and *Developing policies to prevent violence and injuries: guidelines for policy-makers and planners*.[2] Others will be published during the 2008–2009 biennium, for example the *World report on child injury prevention* (2008) and the *World report on disability and rehabilitation*, and the forthcoming global status report on road safety.
- Regional offices have been strengthened and are now better able to support work at country level. Additional resources have also been raised for country-level projects.
- WHO has supported the drafting and adoption of important policy documents, such as the United Nations Convention on the Rights of Persons with Disabilities, resolution WHA60.22 on health systems: emergency care systems and United Nations General Assembly resolution on the promotion and protection of the rights of children.

Achievement of Organization-wide expected results

Adequate support provided to high-priority countries for implementation of information systems for the major determinants, causes and outcomes of violence, unintentional injuries and disabilities

Indicator	Baseline	Target	Achievement
Number of targeted countries that implement functional information systems on the determinants, causes and outcomes of violence, unintentional injuries or disabilities	20	44	45

Fully achieved. In addition to the baseline of 20 countries, an additional 25 countries in all six regions received support from WHO to set up pilot data collection systems, conduct community surveys and develop routine surveillance systems for all injuries, as well as topic-specific systems related to road traffic injuries and violence. Data from these systems are being used to inform national plans and in the prioritization of prevention activities in countries. Several countries have produced national injury and violence reports and two regions are working on publishing regional overview reports on their injury data systems. Policy briefings, fact sheets and web sites have also been devised by the regional offices, bringing together available data and evidence which are then disseminated to a broader audience of policy-makers, practitioners and lay-persons.

Multisectoral interventions to prevent violence and unintentional injuries validated and effectively promoted in countries

Indicator	Baseline	Target	Achievement
Number of targeted countries that implement validated multisectoral interventions to prevent violence and unintentional injuries	19	32	56

Fully achieved. In the countries that implemented interventions to address both violence and unintentional injuries, 13 countries gave priority to violence prevention and 24 countries to unintentional injury prevention (most often of road traffic injuries). Several countries are attempting to monitor and evaluate prevention procedures and measure their impact, usually either at community level or in metropolitan areas or provinces.

Guidance and effective support provided for strengthening of health-care systems for persons affected by violence and injuries

Indicator	Baseline	Target	Achievement
Number of targeted countries that strengthen the prehospital and hospital care system for violence and unintentional injuries	14	26	38

Fully achieved. Support from WHO included the organization of training courses based on WHO guidelines, and site visits and missions by regional and headquarters staff. In addition, key documents, including *Guidelines for essential trauma care*[1] and *Prehos-*

pital trauma care systems[2] have been translated into Arabic, French, Spanish, and Vietnamese and widely disseminated. These activities have assisted countries in upgrading their prehospital trauma care, as well as the capability of hospitals providing care to the injured. Trauma care services have been further strengthened through the work of the trauma and emergency care systems advisory group composed of people involved in trauma care in 12 countries across all regions. The group has advised WHO on related matters and has also disseminated and expressed support for the recommendations contained in the above-mentioned documents.

Effective support provided for strengthening of country capacity for integrating rehabilitation services into primary health care, and for implementation of policies on disability

Indicator	Baseline	Target	Achievement
Number of targeted countries that implement strategies for integrating rehabilitation services into primary health care	4	8	19
Availability of a global analysis of current knowledge on policies and programmes concerning disability	No world report on disability	Work started on a world report on disability	A first draft of most of the world report was available at the end of the biennium

Fully achieved. In total, 19 countries received support consisting of training courses, site visits and missions by WHO regional and headquarters staff for the purpose of strengthening their rehabilitation services. The presence of technical officers specializing in disability and rehabilitation in two regions has improved capacity in those regions to respond to requests from countries for assistance and has led to stronger partnerships with government and civil society. Additional resources and greater multisectoral involvement are required to facilitate the development of regional activities that will guarantee equal opportunities and a good quality of life for people with disabilities.

Work is in progress on the *World report on disability and rehabilitation*: a manager has been recruited and editorial and advisory committees established. A first draft of the report was issued in November 2007 and a final draft incorporating regional-specific data and evidence on various aspects of disability, rehabilitation and care will be reviewed in regional consultations in 2008. The global and national launches are planned to take place in 2009.

Improved capacity in selected countries for framing policy on prevention of violence and injury or on managing disabilities

Indicator	Baseline	Target	Achievement
Number of targeted countries that have national plans and implementation mechanisms to prevent violence and unintentional injuries	16	37	68
Number of targeted countries that have policies on management of disabilities	90	105	133

Fully achieved. Among the 68 countries, some received active support from WHO to develop policies on injury and violence prevention; in others, either WHO acted as a catalyst in policy development or the process was guided by the normative docu-

[1] Mock, C et al. Guidelines for essential trauma care. Geneva, World Health Organization, 2004.

[2] Sasser, S et al. Prehospital trauma care systems. Geneva, World Health Organization, 2005.

ments. Policies on disability and rehabilitation have been formulated in 43 countries across all regions and one additional country has begun drafting its policy. Several other countries are strengthening their programmes on disability management in the absence of a national policy.

Strengthened training capacity in priority countries for prevention of violence and injury and for rehabilitation services

Indicator	Baseline	Target	Achievement
Number of targeted countries that have schools of public health with training programmes on prevention and management of violence and unintentional injuries, and on rehabilitation	13	34	36

Fully achieved. Support was provided for capacity development and associated activities in 36 countries. In addition, a comprehensive modular injury and violence prevention curriculum on CD-ROM known as TEACH-VIP was distributed to more countries and was backed up by four regional training activities. It was also translated into five United Nations languages. A new self-instruction version is being prepared. Following its launch, MENTOR-VIP, a global mentoring programme for injury and violence prevention, has enabled 13 junior injury practitioners from 10 countries to learn specific skills through structured collaboration with a mentor. A chapter on disability and rehabilitation has been incorporated into TEACH-VIP. A position paper has also been elaborated on the need for a curriculum on disability and rehabilitation for schools of public health, medical schools and other training institutions.

Functional global and regional networks that effectively strengthen collaboration between health and other sectors, involving organizations of the United Nations system, Member States and nongovernmental organizations, including those of people with disabilities

Indicator	Baseline	Target	Achievement
Number of global and regional multisectoral networks for prevention of violence and injury and for disability in place with WHO support	8 networks	11 networks	11 networks

Fully achieved. WHO has become increasingly involved in creating and supporting networks that contribute to the sharing of information, the coordination of activities and the development of specific programmes. At global level, the United Nations Road Safety Collaboration, the Violence Prevention Alliance and the global network of ministry of health focal persons for injuries and violence prevention have met several times and have developed jointly a number of activities such as the United Nations Global Road Safety Week and publication of best practice manuals on road safety, in addition to *Preventing injuries and violence: a guide for ministries of health*. Several regional networks of ministry of health focal persons have also been created or reinforced in the Eastern Mediterranean, European, South-East Asia and Western Pacific Regions. Other topic-specific regional networks, such as the Inter-American Coalition for the Prevention of Violence, also continued to expand. In September 2007, WHO's partners met to discuss joint activities related to disability and rehabilitation and expressed support for the Organization's plans in that area.

Lessons learnt and actions required to improve performance

Lessons learnt

- Regular joint planning exercises and exchanges of information across all levels of the Organization through meetings, teleconferences and e-mails have facilitated implementation of harmonized programmes at country and regional level and made it possible to draw on the best resources.
- Budget allocations within WHO and from governments, as well as changes among key staff at country level, threaten the long-term sustainability of projects.
- Partnerships may be time-consuming and slow in making progress, but they are rewarding in the long term, particularly multisectoral partnerships.
- Administrative procedures remain an obstacle to delivering quick responses and delay the implementation of projects. A lack of synchronization between the planning cycles of regional offices and headquarters can also cause difficulties.

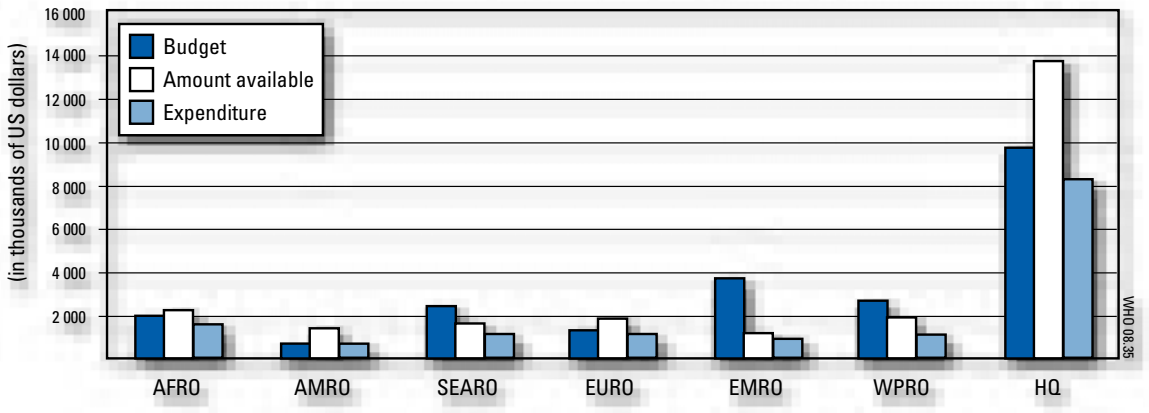
Required actions

- To continue to strengthen collaboration between all levels of WHO and simultaneously rationalize bureaucratic procedures.
- To focus on the sustainability of projects by obtaining long-term commitment from stakeholders before embarking on new activities.
- To continue to invest in the development and maintenance of targeted partnerships.

FINANCIAL IMPLEMENTATION

Violence, injuries and disabilities												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	751	1 246	1 997	604	1 573	2 177	109.0%	604	974	1 578	72.5%	79.0%
AMRO	186	554	740	262	1 191	1 454	196.4%	257	445	702	48.3%	94.9%
SEARO	952	1 491	2 443	983	644	1 628	66.6%	983	285	1 268	77.9%	51.9%
EURO	112	1 186	1 298	155	1 716	1 871	144.1%	155	1 038	1 193	63.8%	91.9%
EMRO	682	3 028	3 710	525	763	1 288	34.7%	525	426	951	73.9%	25.6%
WPRO	434	2 274	2 708	454	1 495	1 949	72.0%	454	667	1 121	57.5%	41.4%
Sub-total Regions	**3 117**	**9 779**	**12 896**	**2 983**	**7 382**	**10 365**	**80.4%**	**2 978**	**3 835**	**6 813**	**65.7%**	**52.8%**
HQ	1 856	7 849	9 705	1 784	11 973	13 757	141.7%	1 746	6 497	8 243	59.9%	84.9%
Total	**4 973**	**17 628**	**22 601**	**4 767**	**19 355**	**24 122**	**106.7%**	**4 724**	**10 332**	**15 056**	**62.4%**	**66.6%**

Violence, injuries and disabilities



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COMMUNICABLE DISEASE RESEARCH (CRD)

WHO objective(s)

To improve and develop tools and approaches which are applicable by developing countries for preventing, diagnosing, treating and controlling neglected infectious diseases, and to strengthen the capacity of disease-endemic countries to undertake the research required for developing and implementing new and improved disease-control approaches.

Indicator(s) and achievement

- *Accessibility to new and/or improved approaches for preventing, diagnosing, treating and controlling neglected infectious diseases in developing countries where they are endemic*. The UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases, with regional and country offices, has been promoting research on: innovation for product development in neglected diseases; evaluation of interventions in real-life settings to inform policy; and implementation of research to inform, and improve access to, quality tools and interventions. The major focus of these activities has been on malaria, TB/HIV coinfection, leishmaniasis, onchocerciasis, dengue, African trypanosomiasis, lymphatic filariasis and Chagas disease. There has been an increased emphasis in recent years on social-research driven activities directed at assessing community-based approaches to health-care delivery for infectious diseases of poverty. This has led to research on the co-implementation of interventions in primary health-care settings. WHO's research output continues to have an impact globally.
- *Extent of input of disease-endemic countries to communicable-disease research*. An increased proportion of disease endemic-countries now have the capacity to play a significant role in international research. WHO, through the Special Programme, strongly encourages participation by developing countries as stakeholders in its meetings and committees and through its commissioned research. This commitment encompasses the provision of focused training and course development and the promotion of networks. Capacity for undertaking laboratory, clinical and social-science research has expanded, as has that for training in key institutions in Africa, Asia and Latin America, as a result of the work of WHO and numerous global, regional and national partners. There is increased emphasis on the promotion and development of research leadership in developing countries, particularly in innovation-driven translation research, converting basic research into tool development and undertaking research to inform policy and its scaled-up implementation.

Main achievements

- Research to inform the implementation of strategies and policies focusing on community engagement in health-care delivery has continued to reap dividends. During the biennium, multi-country studies have demonstrated that community-directed interventions in Africa can be expanded to cover the co-implementation of up to five interventions, including home management of malaria and bed-net distribution. Through the African Programme for Onchocerciasis Control's community-based infrastructure there is potential for a rapid scale up that could have an impact on 60 million people in sub-Saharan Africa.
- The UNICEF/UNDP/World Bank/WHO Special Programme has developed "pre-competitive" innovation networks for drug discovery involving academia and industry from both developed and developing countries. These networks are beginning to propose new drug discovery projects for neglected diseases.

The model has significant value for discussions connected with the work of the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property.

- Guidelines drawn up by an expert panel on diagnostics evaluation, which address point-of-care diagnostic tests in primary health-care settings, have highlighted the need for quality-assured diagnostics. The main impact of this research so far has been in the area of congenital syphilis, but in the 2008–2009 biennium it is anticipated that it will also have a bearing on other diseases.
- The increased engagement of WHO in research at regional level has resulted in several high-level regional and interregional discussions during which research into communicable diseases featured prominently.
- Following an external review and extensive stakeholder consultation, the Special Programme's Joint Coordinating Board approved its 10-year strategy. Its goal is to foster an effective global effort to tackle infectious diseases of poverty in which developing countries will play a pivotal role.

Achievement of Organization-wide expected results

New basic knowledge about determinants (biomedical, social, economic, health systems, behavioural and gender) and other factors of importance for prevention and control of infectious diseases, generated and accessible

Indicator	Baseline	Target	Achievement
■ Number of new, significant and relevant scientific advances in the biomedical, social, economic and public-health sciences	500	500	453 at the time of reporting. As several 2007 articles are not yet included in the databases, the final total is expected to meet the target of 500

Fully achieved. At the time of reporting, a total of 453 scientific articles (260 in 2006 and 193 in 2007) have been identified in peer-reviewed journals (as tracked from electronic databases) which describe new and significant advances in communicable diseases and which have been supported by the UNICEF/UNDP/World Bank/WHO Special Programme and small grants from regional offices. The full list of publications is regularly updated.[1]

New and improved tools, including drugs, vaccines and diagnostic tools, devised for prevention and control of infectious diseases

Indicator	Baseline	Target	Achievement
■ Number of new and improved tools, such as drugs and vaccines, receiving regulatory approval and/or label extensions or, in the case of diagnostic tools, being recommended for use in controlling neglected tropical diseases	3	5	2

Partly achieved. The direct engagement of the UNICEF/UNDP/World Bank/WHO Special Programme in drug development for registration is decreasing with the advent of several product development partnerships. Nevertheless, some projects are being carried out with partner involvement that are moving towards completion for regulatory approval, and others are being supported because no other suitably qualified organization has been identified. During the biennium, regulatory approval was granted to two drugs for which the UNICEF/UNDP/World Bank/WHO Special Programme,

[1] Available at: http://www.who.int/tdr/publications/peer_reviewed_articles/peer_reviewed_diseases.htm

with other organizations, had provided support: an artesunate plus amodiaquine fixed-dose combination for malaria, with DNDi and Sanofi-Aventis; and injectable paromomycin for visceral leishmaniasis, with the Institute for OneWorld Health. Several projects, which did not obtain regulatory approval in 2007, are at a late stage in the registration process and it is expected that approval will be granted during the 2008–2009 biennium. Diagnostics evaluation activities, with evidence for policy anticipated in 2008–2009, are also being carried out for several diseases and will be supported through the development of expert guidelines on the experimental evaluation of diagnostics.

New and improved intervention methods for applying existing and new tools at clinical and population levels developed and validated

Indicator	Baseline	Target	Achievement
Number of new and improved intervention methods validated for prevention, diagnosis, treatment or rehabilitation, for populations exposed to or affected by infectious diseases	0	4	5

Fully achieved. An increased emphasis has been placed on this aspect of research. During the 2006–2007 biennium, evidence generated through research has led to: a revised definition of a new sputum smear-positive pulmonary tuberculosis case; a reduction in the number of specimens to be examined for screening of tuberculosis cases from three to two in places where the workload is very high and human resources are limited; recognition of the importance of clinical complications of lymphatic filariasis in children and that early treatment with DEC plus albendazole leads to a significant reversal of the clinical manifestations of the disease; a WHO recommendation that rectal artesunate should be used in areas of high malaria endemicity for patients unable to take oral treatment prior to referral to hospital; and a new model for integrated analysis of remote sensing and data on rapid assessment procedures for Loiasis (RAPLOA) that will accelerate the mapping of loiasis endemicity and guide ivermectin distribution programmes in Africa. WHO regional offices have devised technical cooperation plans to assist endemic countries, based on a range of studies, to identify specific issues related to determinants of disease, access to health care, evaluation of new approaches and strategies for disease control.

New and improved public-health policies for full-scale implementation of existing and new strategies for prevention and control framed and validated; guidance for application in national control settings accessible

Indicator	Baseline	Target	Achievement
Number of new and improved policies and strategies for enhanced access to proven public health interventions formulated, validated and recommended for use	2	6	3

Partly achieved. Research to inform the implementation of strategies and policies has generated evidence that has led to policy decisions in three instances: community-directed interventions, as adopted by the African Programme for Onchocerciasis Control for ivermectin distribution for the control of onchocerciasis, may be expanded to cover the co-implementation of up to five interventions, including home management of malaria and bednet distribution; an artemisinin combination therapy, such as Coartem, may be administered through community-level distributors despite its more complex treatment regimen; and integrated vector-control strategies incorporating indoor residual spraying, long lasting insecticide-treated nets and environmen-

tal management, having already been shown to be effective in controlling visceral leishmaniasis, have been incorporated into control strategies in India and Nepal. The target of generating evidence to inform six implementation strategies was not fully achieved. In some cases, research activities were delayed and evidence will be made available in 2008 to inform scaled up interventions, for example in the area of dengue vector surveys. In other cases, a lack of funds significantly delayed the implementation of research findings, for example in the case of approaches to fever management in malaria and pneumonia in young children in Africa.

Partnerships established and adequate support provided for strengthening capacity for research, product development and application in disease-endemic countries

Indicator	Baseline	Target	Achievement
Number of new research institutions in low-income disease-endemic countries strengthened	4	3	3
Proportion of new and significant scientific advances produced by scientists from disease-endemic countries	49%	60%	60%

Fully achieved. Research partnerships and networks are an essential component of capacity building within disease-endemic countries. Through them, scientists and institutions in developing countries can acquire local and global leadership status, thus empowering them to deliver innovation and evidence that will have an impact on their national health problems. This activity is supported through research projects, training programmes and networks. In the 2006–2007 biennium, long-term support for research yielded significant results and fostered self-sustainability, notably in three institutions: Pontificia University, Ecuador for research on Chagas disease; Sana'a University, Yemen for research on malaria, promoting links with Sudan, Eritrea and the United Kingdom; and the Kenya Medical Research Institute for drug discovery research using natural products. About 60% of the 453 scientific articles reporting new advances in communicable diseases were published by first-time authors from developing countries.

Technical information and research guidelines accessible to partners and users

Indicator	Baseline	Target	Achievement
Number of new research instruments and guidelines for infectious diseases developed and published	13	15	20
Number of new global research priority-setting reports for neglected infectious diseases published	2	4	4

Fully achieved. There is an increased emphasis globally on publishing articles as a way of improving research standards, supporting research agendas and priority setting. WHO, including through the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases, is playing a significant role

in this area: 20 articles defining and reviewing research concepts, instruments and guidelines have been published, including: *Neglected diseases: a human rights analysis*[2] and *Diagnostics for tuberculosis: global demand and market potential*.[3] Four reports have also been published outlining research priorities for tuberculosis, schistosomiasis, Chagas' disease and dengue.[4]

Lessons learnt and actions required to improve performance

Lessons learnt:

- A coherent approach by multiple stakeholders to addressing commonly agreed agendas and priorities is a prerequisite for sustainability.
- To make full use of their capabilities, research institutions in developing countries should be empowered to assume a leading role in relevant research.
- There continue to be many neglected areas that ought to be the subject of research. They are often at the interface between traditional disciplines, or their impact, whether immediate or future, is underestimated.
- It is necessary to maintain the focus on attainable goals, which are regularly reviewed and adapted when necessary, as well as to monitor and evaluate performance.

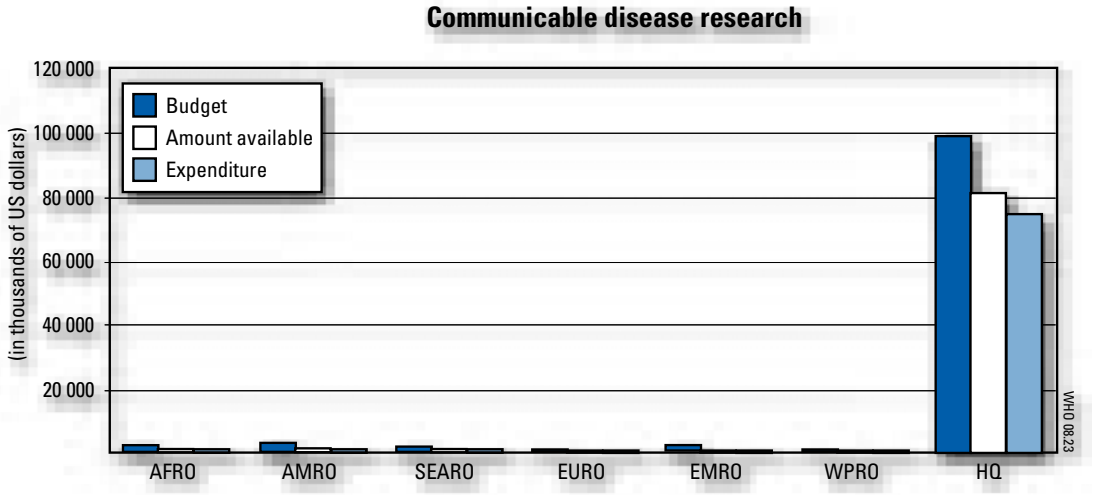
Required actions:

- To implement the new *TDR Business Plan 2008–2013*,[5] as well as the recommendations of the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property, which will be submitted to the Sixty-first World Health Assembly for adoption, and the forthcoming WHO research strategy, which will be submitted to the Sixty-second World Health Assembly.
- To enhance WHO's stewardship role in order to promote coherent agenda setting, and to establish expert reference groups across regions with the task of coordinating and analysing research needs and supporting broad stakeholder consultations. These actions will be accompanied by the establishment, with partners, of a new web-site.[6]
- To empower developing countries and support their leadership through focused research, training and network building. As a result, research will be responsive to regional needs but also cognizant of best practices and the need for quality-assured research systems that take into account ethical, gender, equity and human rights considerations.
- To explore potential new areas where research is needed, for example emergent viral infections and the interface between diseases and the environment, as well as traditional areas. To select and monitor projects on the basis of strategic advice furnished by expert special project teams in addition to traditional funding entities.
- To place a stronger emphasis on reviewing the portfolio of the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases and delivering on its objectives. This will be implemented primarily through its Scientific and Technical Advisory Committee.
- To promote health research and research institutions as an integral component of health systems, especially within the strategic thinking of the international donor community.

[2] Paul Hunt. *Neglected diseases: a human rights analysis.* Geneva, World Health Organization on behalf of the Special Programme for Research and Training in Tropical Diseases, 2007.
[3] *Diagnostics for tuberculosis: global demand and market potential.* Geneva, World Health Organization on behalf of the Special Programme for Research and Training in Tropical Diseases, 2006.
[4] Available at: http://www.who.int/tdr/publications/publications/default.htm.
[5] Available at: http://www.who.int/tdr/about/strategy/pdf/business_plan.pdf.
[6] Available at: http://www.tropIKA.net.

FINANCIAL IMPLEMENTATION

Communicable disease research												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	553	2 032	2 585	71	1 119	1 189	46.0%	71	732	803	67.5%	31.1%
AMRO	124	2 508	2 632	0	1 146	1 146	43.5%	0	558	558	48.7%	21.2%
SEARO	147	1 258	1 405	605	276	881	62.7%	605	252	857	97.3%	61.0%
EURO	0	300	300	0	100	100	33.3%	0	100	100	100.0%	33.3%
EMRO	113	2 337	2 450	0	434	434	17.7%	0	429	429	98.9%	17.5%
WPRO	0	300	300	0	336	336	112.0%	0	239	239	71.1%	79.7%
Sub-total Regions	**937**	**8 735**	**9 672**	**675**	**3 410**	**4 086**	**42.2%**	**676**	**2 310**	**2 986**	**73.1%**	**30.9%**
HQ	2 820	95 965	98 785	2 711	78 207	80 918	81.9%	2 699	71 542	74 241	91.7%	75.2%
Total	**3 757**	**104 700**	**108 457**	**3 386**	**81 617**	**85 003**	**78.4%**	**3 375**	**73 852**	**77 227**	**90.9%**	**71.2%**



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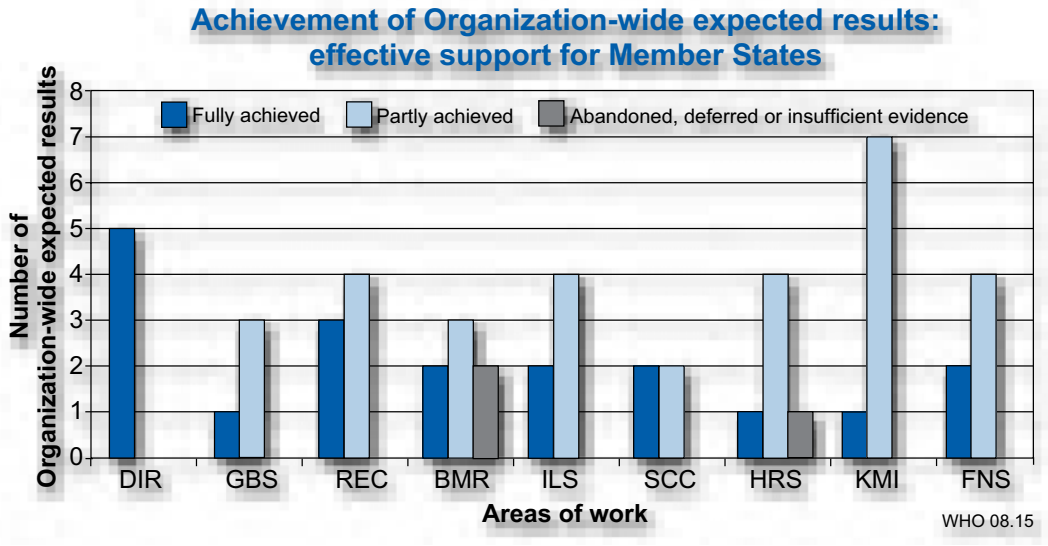
Effective support for Member States

The Effective support for Member States grouping comprises the following areas of work: Direction (DIR); Governing bodies (GBS); External relations (REC); Planning, resource coordination and oversight (BMR); Infrastructure and logistics (ILS); WHO's core presence in countries (SCC); Human resources management in WHO (HRS); Knowledge management and information technology (KMI); and Budget and financial management (FNS).



DIRECTION (DIR)

WHO objective(s)

To direct the work of the Organization within the overall framework of WHO's Constitution, so as to maximize the Organization-wide contribution to the work of Member States in achieving significant gains in health status.

Indicator(s) and achievement

- *Extent of delivery of all areas of work set out in the Programme budget, as reflected in the end-of-biennium performance assessments and programmatic and thematic evaluations*. According to the end-of-biennium performance assessment, the proportion of Organization-wide expected results that were fully attained was 55% (111 of 201) compared to 53% in 2004–2005 and 24% in 2002–2003.

Main achievements

- The Eleventh General Programme of Work 2006-2015 was prepared and endorsed by Member States.
- The WHO Medium-term strategic plan 2008-2013 was prepared and endorsed by Member States.
- Dr Margaret Chan was elected Director-General following the sudden death of Dr LEE Jong-wook. In 2007, Dr Chan implemented a number of structural changes to more closely align all aspects of WHO's work.
- The International Health Regulations (2005) came into force on 15 June 2007.
- Numerous publications were issued including, *The world health report 2006: working together for health*, *The world health report 2007: a safer future: global public health security in the 21st century* and the African Regional Health report.
- The Member States endorsed several key strategies and global plans of action, notably the global immunization strategy,[1] the global strategy for the prevention and control of sexually transmitted infections,[2] the strategy for integrating gender analysis and actions into the work of WHO[3] and the global plan of action on workers' health.[4]

[1] Resolution WHA 58.15.
[2] Resolution WHA 59.19.
[3] Resolution WHA 60.25.
[4] Resolution WHA 60.26.

Achievement of Organization-wide expected results

Effective direction and management of the Organization.

Indicator	Baseline	Target	Achievement
Level of endorsement of reports submitted to the governing bodies	Endorsement of all regular reports on implementation of resolutions and decisions	Endorsement of all regular reports on implementation of resolutions and decisions	Reports from the Regional Directors to the Regional Committees and from the Director-General to the governing bodies were endorsed. Governing bodies' resolutions and decisions were adopted and have guided the Organization's work

Fully achieved. All the resolutions adopted during the biennium have included an addendum showing the associated costs. Improved communication with Member States through regular briefings at regional level and at headquarters have facilitated a clearer understanding of the subjects discussed by the Regional Committees and governing bodies. The Eleventh General Programme of Work and the Medium-term strategic plan have together provided a clear direction for the future of the Organization and the Director-General's six-point agenda confirms that priorities have been set and aligned with the Medium-term strategic plan.

Coherence and synergy between the work of the different parts of the Organization

Indicator	Baseline	Target	Achievement
Degree of collaboration and coordination for Organization-wide programme planning and implementation; and communication of policies and strategies during meetings of senior management across the Organization	All global planning coordinated between senior managers of headquarters and regional and country offices	All global planning coordinated between senior managers of headquarters and regional and country offices	All regions have actively contributed to the Organization-wide Medium-term strategic plan In all regions, regional and country office staff have participated in key meetings and have disseminated information on policy

Fully achieved. All regions have actively participated in preparing the Organization-wide Medium-term strategic plan. Although the communication and coordination aspects of programme planning have improved, substantial progress needs to be made in securing financing for implementation of the programmes. Regional Directors and Deputy Regional Directors met the Director-General and Deputy Director-General at Global Policy Group meetings. Regular retreats attended by senior officers also contributed towards strengthening collaboration and coordination across the Organization. Nevertheless, it has not been possible to gauge the impact of these meetings and a proposal has been put forward for a mechanism to be introduced to measure their impact. The Fourth Global Meeting of the Heads of WHO Country Offices was held in Geneva, from 12–14 November 2007, providing an opportunity for a policy dialogue between the Director-General, the Regional Directors and the heads of WHO country offices. The report of the meeting highlighted 16 action points, each of which will be followed up during the 2008–2009 biennium.

Legal status and interests of the Organization protected through timely and accurate legal advice and services

Indicator	Baseline	Target	Achievement
Responsiveness to requests for legal advice and services	All legal inquiries addressed and documented	All legal inquiries addressed and documented	All legal inquiries have been addressed and documented

Fully achieved. Improved dialogue and communication between the regional offices and the Office of the Legal Counsel at headquarters has made it easier to protect the legal interests of the Organization as a whole, although advice might be given more promptly.

Awareness of Member States and global partners of the work and role of WHO, and its contribution to significant developments in public health infrastructure, services, policy and outcomes

Indicator	Baseline	Target	Achievement
Accuracy of representation of WHO's work in major international, regional and country media	All WHO priority programmes accurately reported to relevant media	All WHO priority programmes accurately reported to relevant media	Timely and evidence-based information has been supplied to international, regional and country media to promote and support an accurate representation of WHO's work

Fully achieved. Several initiatives have been launched to improve communication via the web: PAHO has created "Director's Corner", "Director's Newsletter" and "Director's blog", and in the Regional Office for Europe and at headquarters web content is being upgraded. A coordinating group for media advocacy has been set up in the Regional Office for South-East Asia to improve communication strategies. The Regional Office for Europe convened two ministerial conferences on countering obesity and tuberculosis to address key public health concerns. It is now organizing the first European ministerial conference on health systems, which will take place in June 2008. Several donors have pledged their support. Despite the work that has already been carried out in this area, there is still room for improvement.

Catalytic and start-up funds provided for programmes of particular need under the purview of the Director-General and Regional Directors

Indicator	Baseline	Target	Achievement
Strategic allocation of the Director-General's and Regional Directors' development funds toward activities and initiatives that advance the mission of the Organization	Funds allocated as directed by the Director-General and Regional Directors	Funds allocated as directed by the Director-General and Regional Directors	Important technical cooperation activities that are relevant to the implementation of WHO's collaborative programmes with countries have received support Funds have also been allocated in answer to urgent needs arising from health emergency situations resulting from natural and other disasters

Fully achieved. The development funds were fully disbursed either as start-up funds or for particular needs, such as regional meetings of the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property, avian and pandemic

influenza, veterinary and public health, the Global Links program, multilingualism and community initiatives.

Lessons learnt and actions required to improve performance

Lessons learnt:

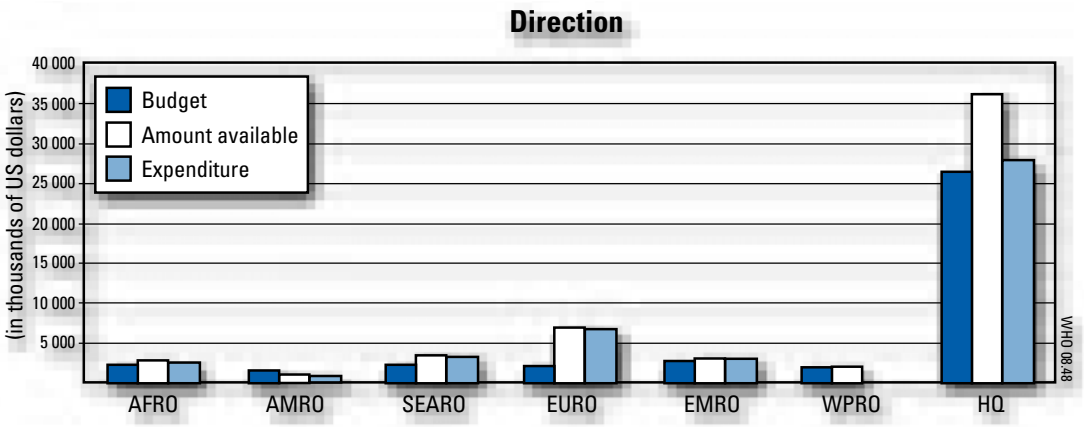
- The meetings and retreats for senior staff are intended to strengthen the Organization, but their impact needs to be further assessed during the biennium.
- Performance management is difficult to achieve and is not always implemented.
- Briefings and consultations involving Member States are an effective way of clarifying governing body agenda items.
- WHO's materials, messages and advocacy methods play an indispensable role in promoting policies among Member States and partners and should be widely disseminated.

Required actions:

- To continue regular retreats for senior staff across the Organization while evaluating their impact and benefits.
- To further strengthen the corporate performance management system using commonly agreed performance indicators.
- To assist regional and country offices to communicate more effectively with the public and media.
- To reduce the number of publications and improve quality.

Financial implementation

Direction												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	1 536	592	2 128	1 437	1 359	2 796	131.4%	1 386	1 096	2 482	88.8%	116.6%
AMRO	939	459	1 398	1 012	115	1 128	80.7%	998	109	1 107	98.1%	79.2%
SEARO	1 932	116	2 048	1 483	1 824	3 307	161.5%	1 483	1 599	3 082	93.2%	150.5%
EURO	1 089	878	1 967	2 216	4 471	6 687	340.0%	2 216	4 459	6 675	99.8%	339.3%
EMRO	2 464	146	2 610	2 875	121	2 996	114.8%	2 875	77	2 952	98.5%	113.1%
WPRO	1 719	102	1 821	1 681	106	1 787	98.1%	1	0	1	0.0%	0.0%
Sub-total Regions	**9 679**	**2 293**	**11 972**	**10 705**	**7 997**	**18 702**	**156.2%**	**8 959**	**7 340**	**16 299**	**87.1%**	**136.1%**
HQ	17 108	9 124	26 232	19 897	16 190	36 088	137.6%	19 871	7 753	27 624	76.5%	105.3%
Total	**26 787**	**11 417**	**38 204**	**30 602**	**24 187**	**54 789**	**143.4%**	**28 830**	**15 093**	**43 923**	**80.2%**	**115.0%**



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GOVERNING BODIES (GBS)

WHO objective(s)

To assure the good governance of WHO through efficient preparation and conduct of the regional and global governing body sessions, and effective policy-making processes.

Indicator(s) and achievement

- *Greater consensus in deliberations of the Health Assembly, Executive Board and regional committees.* Greater consensus among Member States was evidenced by the number of resolutions addressing key health policy and technical issues adopted by governing bodies at headquarters and regional level, as well as by the establishment of formal subsidiary bodies and the use of informal consultation mechanisms to facilitate consensus building and, in consequence, further the work of the Health Assembly with regard to complex matters.

Main achievements

- Conference services were provided to ensure the smooth running of regular meetings of the governing bodies at headquarters and regional levels, thereby ensuring effective policy-making processes.
- Additional governing body meetings were organized and conducted, including special sessions of the Executive Board and the Health Assembly in 2006, subsidiary meetings mandated by Health Assembly resolutions, and two meetings of the Conference of the Parties to the WHO Framework Convention on Tobacco Control, one of which was held in Bangkok.
- All governing body meetings were held in the appropriate official languages, and documentation was provided in the languages prescribed by the rules of procedure of each governing body, or the parent body in the case of subsidiary committees.
- Informal consultations were increasingly held to ensure increased cooperation, communication and policy coordination among Member States and with the Secretariat. This facilitated the successful outcome of governing body meetings at headquarters and regional level.

Achievement of Organization-wide expected results

Resolutions adopted that focus on policy and strategy and provide clear orientation to Member States and the Secretariat on their implementation

Indicator	Baseline	Target	Achievement
Proportion of resolutions adopted that focus on policy and can be implemented at global, regional and national levels	85%	90%	Over 90% of resolutions adopted by WHO governing bodies at headquarters and regional levels have focused on policy
Appropriateness of health contents in resolutions or policies of other bodies in the United Nations system	Nil	At least 1 new area of health interest included per year in meetings of bodies of the United Nations system	2 United Nations General Assembly resolutions were adopted on enhancing capacity-building in global public health[1] and World Diabetes Day.[2] The Commission on the Status of Women adopted a resolution on female genital mutilation.[3] Other health-related topics, such as tobacco control, road safety, human resources for health and malaria, also continued to feature in United Nations General Assembly and United Nations Economic and Social Council discussions
Effectiveness of governing body processes, as assessed against outcomes of Executive Board sessions and Health Assemblies	Nil	Assessment of the role of the Programme, Budget and Administration Committee by the Executive Board	No formal assessment of the work of the Programme, Budget and Administration Committee was conducted

Partly achieved. The regional offices have contributed towards the development and adoption of a number of resolutions at global level. There has been coordination and interaction with Member States and technical units, and enhanced collaboration between headquarters and the regions. However, the number of meetings of governing bodies and their subsidiary committees has continued to increase without a corresponding adjustment in human resources. Although no formal assessment of the work of the Programme, Budget and Administration Committee was conducted, its reports have facilitated discussions on subjects related to programming, the budget and administration during sessions of the Executive Board and in Health Assemblies.

Communication between Member States, Executive Board members and the Secretariat improved

Indicator	Baseline	Target	Achievement
Frequency of effective use of communication channels between Member States and governing bodies at global, regional and country levels, concerning the work of WHO	1 major	2 major	One intergovernmental consultation was conducted by electronic means at headquarters; none was conducted at regional level

Partly achieved. Headquarters and all regional offices provided electronic access to their respective governing body documents in relevant languages. Although the Virtual Executive Board facility exists, Board members did not use it for consultations. However, electronic consultations were conducted during intergovernmental discussions related to the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property. Partners tend to rely on more "traditional" mechanisms for intergovernmental consultations, hence ways of enhancing use of electronic means of consultation among Member States need to be explored further.

Governing body meetings held in all the official languages of WHO at global level and in agreed official languages for the regional committees

Indicator	Baseline	Target	Achievement
Proportion of governing body meetings held in appropriate official languages	100%	100%	100%
Timeliness of documentation in the official languages	90%	95%	95% at regional level, but not at headquarters
Improvements in multilingualism in WHO	Top pages of headquarters' web site in the 6 official languages	Additional material on headquarters' web site in the 6 official languages	All governing body documents were made available on the WHO web site in all six official languages

Partly achieved. More governing body meetings were serviced at headquarters. Eleven regular meetings and a further eight meetings, including subsidiary body meetings, were held at headquarters and conducted in all six official languages. Regional governing body meetings were conducted in the official languages of the respective region and were fully serviced. As regards timelines of documents in the official languages, documentation and records services were provided for 11 scheduled meetings and 8 additional governing and subsidiary body meetings held at headquarters during the biennium. Delays continued to be caused by the late receipt of draft documents from authors. Governing body documents were delivered on time in all regions. The increase in the number of meetings held at headquarters, and having to service them with the same level of resources, are the main reasons for delays in the delivery of documents for governing body meetings at headquarters. While governing body documents are now more often available in relevant official languages at headquarters and in regional offices, quality control needs further strengthening. The improvements that have been made have largely been achieved through the dedication of staff members despite an increase in their workload and insufficient resources for providing the services required. However, any gains in efficiency cannot be sustained without adequate resources. The late delivery of some draft documents by technical and management units also hinders efforts to improve efficiency.

Communication and coordination in establishing the work programmes of regional and global governing bodies improved

Indicator	Baseline	Target	Achievement
Degree of congruence of agendas and resolutions of the regional and global governing bodies	Agendas and resolutions of global governing bodies considered by regional committees when establishing their own agendas	Officers of the Executive Board consider regional committee agendas and resolutions when planning the Board's January agenda	Regional priorities continued to receive adequate attention in planning the Executive Board agenda

Fully achieved. Matters regarded by regional offices as being of global relevance were considered for inclusion on the agenda of governing body meeting held at headquarters. For example, the Regional Committees for South-East Asia and the Western Pacific Regions proposed that climate change and health should be considered at headquarters level, after which it was included on the agenda of the 122nd session of the Executive Board. Regional governing body meetings continued to consider agenda items related to those on the agendas of governing body meetings held at headquar-

ters. Clearer communication between headquarters and regional focal points has been responsible for improvements in this area, however, interaction and collaboration need to be further enhanced.

Lessons learnt and actions required to improve performance

Lessons learnt:

- Discipline at all organizational levels is crucial for the preparation and conduct of governing body meetings and the provision of documentation in accordance with WHO's Constitution.
- The increase in the number of additional meetings of governing and subsidiary bodies, as well as in associated services, must be catered for appropriately.
- Early consultation between authors, editors and senior management ensures that governing body documentation is of a high quality and is delivered on time.
- The indicators need refining to improve outcomes.

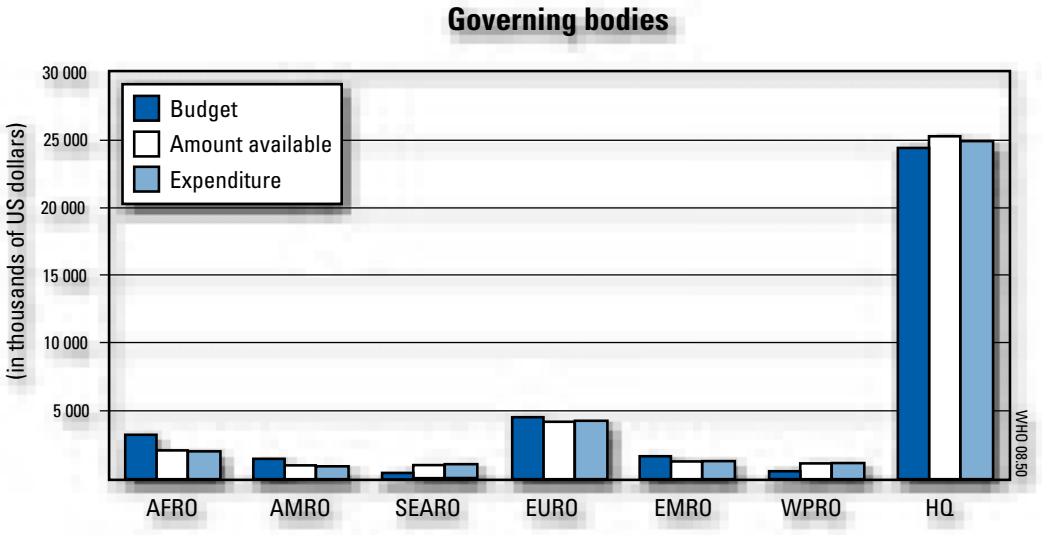
Required actions:

- To increase awareness in technical and management units of the need to assign high priority to governing body meetings and their documentation.
- To ensure that enough human resources are available for managing the increased workload occasioned by the greater number and frequency of meetings of governing bodies and their subsidiary committees.
- To continue to improve communication and coordination with Member States.

[1] Resolution A/RES/60/35.
[2] Resolution A/RES/61/225.
[3] Resolution 51/2.

Financial implementation

Governing bodies												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	1 287	1 855	3 142	1 184	865	2 049	65.2%	1 184	865	2 049	100.0%	65.2%
AMRO	647	689	1 336	901	9	910	68.1%	878	9	887	97.4%	66.4%
SEARO	283	17	300	359	566	925	308.3%	359	566	925	100.0%	308.3%
EURO	4 015	319	4 334	3 951	139	4 090	94.4%	3 951	139	4 090	100.0%	94.4%
EMRO	846	677	1 523	1 059	119	1 178	77.3%	1 059	119	1 178	100.0%	77.3%
WPRO	414	25	439	425	610	1 035	235.7%	425	610	1 035	100.0%	235.8%
Sub-total Regions	**7 492**	**3 582**	**11 074**	**7 878**	**2 308**	**10 187**	**92.0%**	**7 856**	**2 308**	**10 164**	**99.8%**	**91.8%**
HQ	17 441	6 864	24 305	18 955	6 269	25 224	103.8%	18 954	5 805	24 759	98.2%	101.9%
Total	**24 933**	**10 446**	**35 379**	**26 833**	**8 576**	**35 410**	**100.1%**	**26 810**	**8 113**	**34 923**	**98.6%**	**98.7%**



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External relations (REC)

WHO objective(s)

To negotiate, sustain and expand partnerships for health globally; to strengthen WHO's collaboration with intergovernmental and governmental bodies, civil society organizations, the private sector and foundations; and to secure the Organization's resource base.

Indicator(s) and achievement

- *Effectiveness of interaction with governmental, intergovernmental and other multilateral agencies, the private sector and civil society.* Several health objectives have been expanded as a result of and interaction with 90 global health initiatives and partnerships, official relations with 186 nongovernmental organizations, and collaborative mechanisms with United Nations agencies, Bretton Woods Institutions and intergovernmental and regional organizations.

Main achievements

- Consultations and coordination have taken place with United Nations system agencies, funds and programmes, and WHO has participated more actively in United Nations reform.
- WHO guidelines on working with the private sector have been applied and have served to increase organizational experience and create new opportunities.
- Several networks of health-sector stakeholders have contributed to the development of key areas, including health security, avian influenza and pandemic preparedness, the International Health Regulations (2005), HIV/AIDS, tuberculosis, noncommunicable diseases, tobacco control, health research, maternal and newborn health and health systems strengthening.
- The involvement of private, nongovernmental, academic and other sectors increased during the biennium.
- The prominence of health development has increased in international and regional forums, among others, the United Nations General Assembly, the G8 group of countries, the European Union, the African Union, the Bretton Woods Institutions, the United Nations Economic and Social Council, the Organisation of the Islamic Conference, the International Organization for Migration and the International Federation of Red Cross and Red Crescent Societies.
- A total of 186 nongovernmental organizations now have official relations with WHO.
- WHO has acted as a leader in the United Nations reform process and the eight pilot country programmes, including in aligning country-led activities, harmonizing business practices and engaging with regional directors' teams.

- Because of WHO's work, health has been used as a tracer sector by the OECD's Development Assistance Committee.
- WHO regional offices have increased their participation in regional meetings and institutions: the Regional Office for Africa has worked more closely with the African Union, the WHO Regional Office for the Americas/PAHO has participated in the Joint Summit Working Group and other forums responsible for organizing the Summits of the Americas; and the Regional Office for South-East Asia has carried out joint activities with ASEAN.
- More interaction with regional development banks, for example the Asian Development Bank, the African Development Bank and the Inter-American Development Bank over, *inter alia*, avian influenza, health security and impact assessment, has proved mutually beneficial.

Achievement of Organization-wide expected results

Sustained and expanded partnerships for health globally; strengthened collaboration with intergovernmental and governmental bodies, civil society organizations, the private sector and foundations

Indicator	Baseline	Target	Achievement
Number of consultation and briefing sessions with WHO's sister agencies, other organizations and interested parties in the health sector	Annual, biennial and ad hoc meetings with UNDP, UNICEF, UNFPA, European Commission, World Bank and other bodies such as the Global Alliance for Vaccines and Immunization or the Global Fund to Fight AIDS, Tuberculosis and Malaria	Periodic meetings with WHO's sister agencies and health-related organizations	Periodic meetings have taken place with UNDP, UNICEF, UNFPA, WFP, the European Commission and the World Bank, as well as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Global Alliance for Vaccines and Immunization. The number of meetings has increased steadily as more entities become engaged in health
Number of policy areas where there is congruence with other stakeholders	Congruent policies on family health and on immunization	At least 2 new policies framed per biennium	5 new policies and frameworks on family health and immunizations have been jointly developed with other United Nations agencies and global health partnerships

Fully achieved. Headquarters and regional and country offices have participated in numerous joint actions which have led to the development and adoption of policies that give priority to health, such as the G8 summit in St. Petersburg in July 2006, which addressed health security, and European Union high-level and senior officials meetings. It has actively engaged with the European Union and the European Commission in specific health areas, such as tobacco control, physical health, tackling health workforce problems in Africa, and in connection with the International Health Regulations (2005). WHO has also participated regularly in working parties of the OECD's Development Assistance Committee on health and aid effectiveness. As part of a joint effort by WHO and the African Union to tackle HIV/AIDS, tuberculosis and malaria, the Regional Office for Africa worked with the African Development Bank, UNAIDS, UNFPA, UNICEF and the World Bank to develop an action framework on Harmonization for Health in Africa.

WHO has participated in joint meetings of UNDP, UNICEF, UNFPA and WFP and has had regular interaction with the Global Alliance for Vaccines and Immunization and the Global Fund to Fight AIDS, Tuberculosis and Malaria by serving on their boards and committees. WHO headquarters and regional and country offices have also provided assistance to countries in elaborating proposals for submission to these entities, as well as technical support for the implementation, monitoring and evaluation of projects. Compatible policies on family health and immunization have been formulated with UNICEF, UNFPA and the World Bank. They include: indicators and

guidelines for emergency obstetric care activities; development of maternal and neonatal health policies in several countries and regions as part of the Strategic Partnership Program; and the issuing of joint statements on case management and drug use linked to maternal and neonatal health. A three-year WHO–GAVI framework agreement has been reached which should stabilize and increase the financial resource base for WHO's future work on immunization. The launch of new global initiatives to reduce maternal deaths has led to several joint advocacy activities involving nongovernmental organizations, the United Nations, professional bodies and other partners.

Effective cooperation within the United Nations system including the Bretton Woods and regional institutions that influence the role of health in development

Indicator	Baseline	Target	Achievement
Availability of mechanism for formal policy dialogues and consultations within the United Nations system, Bretton Woods and regional institutions	Mechanism agreed	Mechanism implemented; 1 formal annual meeting with each institution	Mechanisms are in place to ensure formal and informal policy dialogue with United Nations agencies, Bretton Woods Institutions and regional bodies, including at least 10 formal meeting during the biennium

Fully achieved. Throughout the biennium, WHO has engaged with the United Nations system, Bretton Woods Institutions and regional bodies. WHO's collaboration with the World Bank contributed to the Bank's new strategy on health, nutrition and population and should enhance their joint work. WHO has been an active participant in the United Nations system's Chief Executive Board for Coordination and Millennium Development Goals follow-up activities, as well as key United Nations policies on climate change, decent work initiatives and harmonizing business practices. WHO has also played a central role in the United Nations Development Group's activities related to United Nations reform, pilot country programmes, stocktaking, United Nations Country Team work, and the Resident Coordinator selection process.

Resource base for WHO secured

Indicator	Baseline	Target	Achievement
Level of voluntary contributions	Funding level of Programme Budget 2004–2005	Full funding of the Proposed programme budget 2006–2007	An absolute level of available resources was received which exceeded the amount required to fund the Programme budget. However, due to donor earmarking, some areas of work and offices remained underfunded while others were overfunded

Partly achieved. In 2006–2007, the total level of voluntary contributions received exceeded the level required to fund the approved Programme Budget. However, there was not full alignment between resources received and the planned levels, so that some areas of work and offices remained underfunded. The average amount of available resources relative to targets was marginally lower in 2006–2007 than in 2004–2005, with a greater variance in available resource levels across different programmes and regional offices.

Overall, WHO was able to mobilize resources for public health, but it must ensure that it does so equitably across priorities as Programme budget levels continue to grow.

Effective mechanism for coordination of input to and feedback from important international forums, including major United Nations conferences and summits, and the Millennium Development Goals

Indicator	Baseline	Target	Achievement
Degree of reflection of WHO's health goals and priorities in final declarations and plans of actions of global, regional and national conferences, and development agendas	Work of WHO included in the Secretary-General's report on the Millennium Development Goals to the United Nations General Assembly in 2005	Inclusion of health goals adopted by the Health Assembly in the outcome of appropriate global policy meetings	Several key health goals adopted by the Health Assembly have been included in broader settings, such as the United Nations General Assembly. These include United Nations General Assembly resolutions on malaria, World Diabetes Day, persons with disabilities and support for the Secretary-General's reports on violence against children and on infectious diseases

Fully achieved. WHO has responsibility for providing reports on the health-related Millennium Development Goals on behalf of the United Nations for inclusion in the Secretary-General's and other United Nations reports. WHO's support for Member States and the United Nations helped ensure that the following United Nations General Assembly resolutions were adopted: 2001–2010: Decade to Roll Back Malaria in Developing Countries, Particularly in Africa (61/228), World Diabetes Day (61/225) and the Convention on the Rights of Persons with Disabilities (61/106). WHO also played a key role in the preparation of United Nations Secretary-General's report on violence against children[1] and his introduction to the WHO report on Enhancing capacity-building in global public health.[2] WHO organized two special thematic sessions: at an informal special event hosted by the United Nations Economic and Social Council in November 2005 on avian influenza, and on the International Health Regulations (2005) for the United Nations General Assembly. Several resolutions adopted by the General Assembly at its Sixty-first session are of particular relevance to WHO. They include: Audit and investigative reviews of the tsunami relief operations conducted by the United Nations Secretariat, funds and programmes and the specialized agencies (61/265), Comprehensive review of governance and oversight within the United Nations and its funds, programmes and specialized agencies (61/245), Implementation of the Declaration on the Granting of Independence to Colonial Countries and Peoples by the specialized agencies and the international institutions associated with the United Nations (61/231), International cooperation against the world drug problem (61/183), Follow-up to the Fourth World Conference on Women and full implementation of the Beijing Declaration and Platform for Action and the outcome of the twenty-third special session of the General Assembly (61/145), Strengthening of the coordination of emergency humanitarian assistance of the United Nations personnel (61/134), Strengthening emergency relief, rehabilitation, reconstruction and prevention in the aftermath of the Indian Ocean tsunami disaster (61/132), Effects of atomic radiation (61/109) and Sport as a means to promote education, health, development and peace (61/10). WHO's engagement with the Development Assistance Committee of the OECD resulted in health being adopted as a tracer sector for aid effectiveness. Similarly, by working with the African Union and United Nations agencies, a number of health policies on avian influenza, sexual and reproductive health and HIV/AIDS have been endorsed in African Union resolutions. Through PAHO's partnership with the Summit of the Americas, health topics, including ageing, social protection, communicable diseases and human resources for health, have acquired greater prominence.

1 Pinheiro, P.S. *World report on violence against children.* United Nations Secretary-General's Study on Violence against Children, 2006.
2 Document A/61/383.

Added value of private sector involvement in public health programmes improved through a selective approach towards partners

Indicator	Baseline	Target	Achievement
Constructive interaction with private sector entities	Adapted guidelines on interaction with the private sector	Application throughout the Organization of guidelines on interaction with the private sector	WHO guidelines on working with the commercial sector have been fully implemented throughout the Organization
WHO's capability to develop constructive partnerships with public and private sector entities	Review of health partnerships involving WHO	Policy conclusions and recommendations on WHO's role in public-private partnerships	Policy review and recommendations were largely completed concerning WHOs engagement with various public-private partnerships
Assessments, advisory inputs and recommendations on relationships with the private sector, including managing conflict of interests, provided to the Committee on Private Sector Collaboration and to senior management	150 assessments, advisory inputs and recommendations provided per biennium	Facilitation provided including introduction of measures to manage conflict of interest with the private sector	WHO guidelines on working with the commercial sector have been fully implemented throughout the Organization
Proportion of nongovernmental organizations in official relations with WHO on which essential information such as membership and financing is available	Less than 10%	30%	Approximately 30 % of nongovernmental organizations in official relations with WHO provided essential financial and membership information

Partly achieved. WHO's engagement with various private sector entities has increased, while guidelines designed as a safeguard against any undue or inappropriate influence have been respected. In line with these guidelines, several recommendations and best practices on donations, converging interest, conflict of interest, the role of the private sector in multilateral partnerships and resource mobilization among the general public have been implemented. All requests for collaboration have been scrutinized and guidelines for Goodwill Ambassadors have been issued. A record of WHO's collaboration with the private sector has been compiled for future reference. A revised policy on WHO's relations with nongovernmental organizations has been formulated and collaboration with 186 nongovernmental organizations and foundations strengthened. At headquarters, information on existing nongovernmental organizations in official relations with WHO and those that have recently been admitted continued to be made available to the Executive Board through reporting mechanisms that are accessible by the public in all languages. A project to increase knowledge and information about the extent of WHO's interaction with nongovernmental and civil society organizations was cancelled due to a lack of resources and difficulties with the software programme.

Transparency improved and access increased to knowledge about nongovernmental organizations in official relations and interactions with nongovernmental and other civil society organizations

Indicator	Baseline	Target	Achievement
Proposal for a revised policy for relations with nongovernmental organizations and other partners	Health Assembly decision on new policy for WHO's relations with nongovernmental organizations	Revised policy for WHO's relations with nongovernmental organizations	WHO continues to assess and submit applications to enter into official relations with the Executive Board from nongovernmental organizations

Partly achieved. A number of managerial and programmatic changes at headquarters during the biennium led to priority being given to reviewing partnerships. This may have implications for WHO's policy on relations with nongovernmental organizations and there may be a need for harmonization. For this reason work on a revised policy was deferred. In accordance with the existing policy, the Executive Board continued to review triennial reports on collaboration or on the status of some 200 nongovernmental organizations in official relations with WHO, as well as applications for admission into official relations. Regional offices reported keen participation by civil society organizations in their programmes, as well as in ministerial conferences, and strengthened collaboration with civil society at country level. In the Region of the Americas, guidelines for working with the private sector were developed.

Health Academy programme extended to pilot Member States in all regions

Indicator	Baseline	Target	Achievement
Number of Member States in which the Health Academy is established	Health Academy established in 12 countries	Health Academy established in 20 countries (in all regions)	3 countries in 2 regions

Partly achieved. The Health Academy was active in the African and Eastern Mediterranean Regions. Other regions expressed interest in the programme, but resources were not available. The Health Academy project was also introduced to Gulf Cooperation Council countries in an official workshop in Riyadh, Saudi Arabia.

Lessons learnt and actions required to improve performance

Lessons learnt:

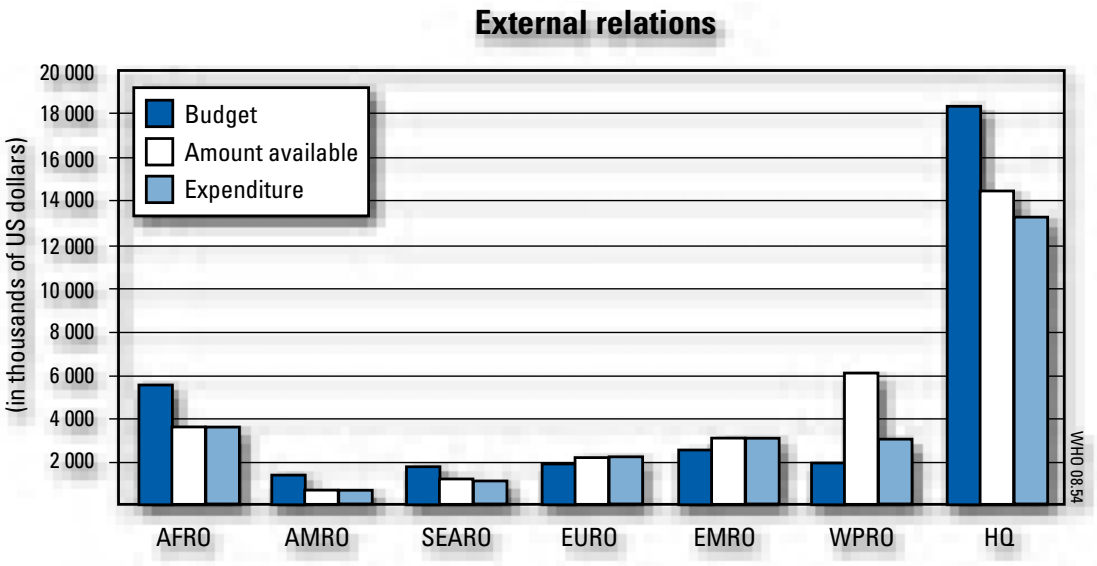
- Continuing to coordinate activities with the United Nations system, regional organizations and the Bretton Woods Institutions is essential for ensuring that health remains high on the international agenda.
- Managing a complex health environment that includes partnerships requires significant assistance from WHO to countries, particularly for partnerships that provide financing for health.
- Open discussions with the private sector and with nongovernmental organizations improve mutual knowledge and understanding and stimulate dialogue on different health topics. WHO guidelines play a key role in articulating WHO's operational procedures.

Required actions:

- To provide WHO guidelines and criteria that clearly define the extent of WHOs role, in health partnerships. They should include measures to improve accountability and ensure clear governance.
- To continue monitoring, assessing, and participating in United Nations reform processes at country, as well as at senior United Nations management level, while taking into account both the overall reform process and agency specificity.
- To make United Nations reform and its effect on structured health partnerships and partnerships in general clearer, while working with the private sector and developing alliances with nongovernmental organizations.
- To train additional staff and equip them with the necessary communication and presentational skills, as well as the ability to build partnerships.
- To strengthen WHO's capacity to form partnerships with sectors that are relevant to development and health, as well as relationships with global, regional and subregional institutions not necessarily related to health.
- To build on existing relationships with the private sector and nongovernmental organizations, and develop new ones with other sectors.

FINANCIAL IMPLEMENTATION

External relations												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	2 257	3 233	5 490	1 549	2 033	3 582	65.2%	1 549	1 972	3 521	98.3%	64.1%
AMRO	1 156	154	1 310	618	97	714	54.5%	601	85	686	96.0%	52.4%
SEARO	0	1 728	1 728	0	1 235	1 235	71.5%	0	1 116	1 116	90.4%	64.6%
EURO	1 762	104	1 866	1 560	633	2 193	117.5%	1 560	582	2 142	97.7%	114.8%
EMRO	1 689	729	2 418	2 033	975	3 008	124.4%	2 033	975	3 008	100.0%	124.4%
WPRO	1 063	714	1 777	926	5 032	5 958	335.3%	926	2 047	2 973	49.9%	167.3%
Sub-total Regions	**7 927**	**6 662**	**14 589**	**6 686**	**10 004**	**16 690**	**114.4%**	**6 669**	**6 777**	**13 446**	**80.6%**	**92.2%**
HQ	9 856	8 381	18 237	8 955	5 397	14 351	78.7%	8 950	4 284	13 234	92.2%	72.6%
Total	**17 783**	**15 043**	**32 826**	**15 641**	**15 400**	**31 041**	**94.6%**	**15 619**	**11 061**	**26 680**	**86.0%**	**81.3%**



* *Amount available figures are not represented as such in the Financial Report and Audited Financial Statements, but include elements of both income received during 2006-2007 and amounts carried forward from the opening fund balances at 1 January 2006.*

Planning, resource coordination and oversight (BMR)

WHO objective(s)

To implement fully functional Organization-wide systems and mechanisms for results-based management that provide effective support for WHO's accountability policy and country focus.

Indicator(s) and achievement

- *Proportion of expected results that are fully achieved at each organizational level.* Organization-wide collation of information shows that 54% of office-specific expected results (5044 of 9305), 78% of regional expected results (769 of 981), and 55% of Organization-wide results (111 of 201) were fully achieved during the biennium.
- *Degree of integration of evaluation recommendations into WHO's managerial process.* All recommendations were reviewed and accepted by evaluees.

Main achievements

- WHO's results-based management framework was renewed during the biennium. This involved transitioning from a biennial to a six-year strategic planning cycle, and introducing more inclusive, horizontal planning and programming by shifting programmatic focus from 36 areas of work to 13 strategic objectives.
- The Eleventh General Programme of Work, the Medium-term strategic plan 2008–2013 and the Programme budget 2008–2009 were prepared, finalized and endorsed through a broadly participatory Organization-wide process.
- A stringent review of budget ceilings by strategic objective, budget centre and budget segment was conducted as part of the Programme budget 2008–2009 development process.
- A record level of funding (US$ 4.257 billion) was made available to WHO during the 2006–2007 biennium, of which a higher proportion was in the form of flexible funding.
- Systems and procedures for managing and allocating voluntary funds, referred to as corporate account funds, which can be deployed in support of the Programme budget in any office, were introduced, with oversight by the Advisory Group on Financial Resources.
- Planning, resource mobilization and programming policies, processes, rules and procedures were reviewed, updated and streamlined in preparation for the introduction of the global management system.

Achievement of Organization-wide expected results

WHO's revised managerial framework and its related processes applied in a coordinated and consistent manner for strategic planning, biennial programming and budgeting, operational planning, performance monitoring and reporting, including support for the country focus

Indicator	Baseline	Target	Achievement
At each organizational level, proportion of areas of work for which workplans have been developed and monitored and which are fully consistent with strategic plans and the programme budget	50%	75%	100%: in the regions, all areas of work have produced and monitored workplans consistent with strategic plans and the programme budget. At headquarters, 97 % of areas of work (35 out of 36) have developed workplans consistent with strategic plans and the programme budget, but only 63% of areas of work (23 out of 36) have provided evidence of having monitored implementation of their workplans

Partly achieved. The consistency and integration of both strategic and operational planning across all three levels of the Organization improved during the biennium. Preparation of the Eleventh General Programme of Work, the Medium-term strategic plan 2008–2013 and the Programme budget 2008–2009 provided an opportunity for broadening staff involvement across the Organization in results-based planning and budgeting processes. Revisiting planning, programming and budgeting policies, processes, rules and procedures in preparation for the introduction of the global management system also provided an opportunity for strengthening planning, monitoring, budgeting and the reporting of knowledge and practices. Other managerial improvements included: ensuring a broadly participatory strategic planning process, timely updating of renewed operational planning rules and procedures, and training in support of the new managerial framework. However, monitoring and assessment procedures were applied less consistently, especially at headquarters. These aspects require greater attention in order to consolidate the gains made and strengthen links between results-based and performance management.

Global system for planning, mobilization, coordination and administration of voluntary resources in support of results-based management and the country focus applied throughout the Organization

Indicator	Baseline	Target	Achievement
Proportion of headquarters programmes, and regional and country offices in which the Organization-wide system for planning, mobilization, coordination and administration of voluntary resources is consistently applied	None	100%	100%: the Organization-wide system was consistently applied in all headquarters' programmes and in regional offices. At country level, Organization-wide collation of information shows the system is consistently applied in 57% of country offices

Partly achieved. The corporate account mechanism, which aims to ensure allocation of corporate account funds where they are most needed, allows more systematic and transparent management and allocation of core voluntary funds across the Organization. A similar system has been introduced in the Regional Office for Africa. In the Regional Office for Europe, a "roadmap" giving an overview of available funds, expenditures and unmet needs by area of work, expected result or country office proved to be a useful tool for making decisions on resource allocation. However, the quality of plans intended to support such decisions varied across offices, and systems for planning, mobilizing, coordinating and administering funds were not always applied rigorously enough.

Capacity for quality assurance services strengthened and advice and assistance provided to make programme delivery across all levels of the Organization more relevant and cost effective

Indicator	Baseline	Target	Achievement
Proportion of programme managers' requests for assistance in making programme delivery more relevant and cost effective fulfilled	None	75%	Precise number of requests received and fulfilled not known and the level of advice varied

Insufficient evidence. Peer review was widely employed at headquarters and in all regions as a means of assuring quality, especially in relation to operational plans. In the African Region, end-of-biennium assessment findings were also peer reviewed prior to dissemination. The systematic reviewing of quality and validation of operational plans was also broadly implemented. However, a systematic, Organization-wide approach to quality assurance based on agreed rules, procedures and systems is still lacking at all stages of the results-based management cycle, and validation of indicators to ensure the relevance and clarity of measures still needs to be improved.

Culture and practice of results-based management sustained at all levels of the Organization

Indicator	Baseline	Target	Achievement
Proportion of professional staff, at each level of the Organization, trained in the principles and practices underlying the revised WHO results-based managerial framework (strategic and operational planning, performance monitoring, quality assurance, evaluation and reporting)	10%	75%	53%

Partly achieved. Training initiatives, coupled with the enhancement of knowledge through staff participation in strategic and operational planning processes, has strengthened results-based management and results-based budgeting practices. However, target figures for training were not met in all offices. For example, in the Regional Office for Europe, staff shortages forced some training activities to be postponed until the 2008–2009 biennium. Furthermore, the quality of training varies owing to the absence of a certification process.

A globally compatible programme management information system fully in operation, that integrates data from all levels of the Organization, and supports efforts to improve performance and accountability at all levels, and to focus on country work

Indicator	Baseline	Target	Achievement
Proportion of agreed core data set that is provided in workplans at each level of the Organization and captured in the global database	None	75%	A decision was taken to invest in the global management system rather than proceed with implementation of a globally compatible programme management information system

Abandoned. Plans for a global database were abandoned early in the biennium in order to concentrate efforts and resources on the development of the global management system, which will provide a more comprehensive, fully integrated global solution.

WHO's work systematically evaluated to assess its medium-term impact and ensure good stewardship of the Organization's resources

Indicator	Baseline	Target	Achievement
Number of thematic and programmatic evaluations completed during the biennium in accordance with the framework on programmatic evaluation	None	8	12

Fully achieved. In addition to the eight programmatic and thematic evaluations and programme performance audits, four country performance audits were conducted. As a result of training events and direct participation in evaluation exercises, knowledge of evaluation practices is reported to have increased in the African, European and Western Pacific Regions.

Risks to the Organization identified and mitigated by controls designed to ensure good corporate governance

Indicator	Baseline	Target	Achievement
Level of implementation of annual audit plans	Fulfilment of annual audit plan	Fulfilment of annual audit plan	Annual audit plan was fulfilled

Fully achieved. Recommendations designed to help manage risk, maintain controls and ensure effective governance within the Secretariat were made.

Lessons learnt and actions required to improve performance

Lessons learnt:

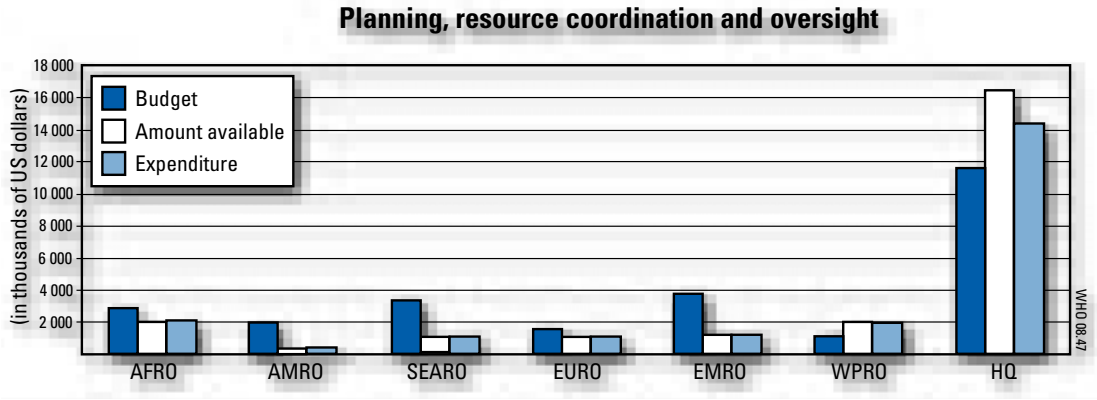
- Wide-scale consultation and participation across the Organization were crucial elements in the development of the Medium-term strategic plan 2008–2013 and the Programme budget 2008–2009 as they broadened the sense of ownership throughout WHO.
- Wider use of peer review during planning, as well as the appointment of a Quality Assurance Committee for the Programme budget performance assessment process, has led to noticeable improvements in the quality of plans and assessment reports.

Required actions:

- Capacity-building efforts in support of the planning and programming approaches necessitated by the Medium-term strategic plan 2008–2013, as well as for the introduction of the global management system need to be redoubled.
- Performance monitoring and assessment must be strengthened and findings better employed when making decisions about programming and resource allocation. This requires a sharpening of the indicators, baselines and targets, and more effective employment of performance results when assessing technical and financial implementation.
- Sustained efforts are required to ensure that the scheduled dates for introduction of the global management system are respected.
- Use of peer review and other quality assurance mechanisms should be expanded and improved.
- Work on disaggregating the Programme budget into recognizable segments, such as base programmes, partnerships and outbreak and response activities, needs to be pursued in order to inform analysis, costing and planning of the Programme budget 2010–2011.

Financial implementation

Planning, ressource coordination and oversight												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	1 459	1 309	2 768	1 337	713	2 051	74.1%	1 337	712	2 049	99.9%	74.0%
AMRO	1 416	501	1 917	134	183	317	16.6%	122	183	305	96.1%	15.9%
SEARO	1 317	1 968	3 285	736	375	1 111	33.8%	736	371	1 107	99.6%	33.7%
EURO	589	859	1 448	655	389	1 044	72.1%	655	388	1 043	99.9%	72.0%
EMRO	2 076	1 647	3 723	1 148	28	1 176	31.6%	1 148	28	1 176	100.0%	31.6%
WPRO	944	50	994	1 853	29	1 883	189.4%	1 853	29	1 882	100.0%	189.3%
Sub-total Regions	**7 801**	**6 334**	**14 135**	**5 864**	**1 718**	**7 582**	**53.6%**	**5 851**	**1 711**	**7 562**	**99.7%**	**53.5%**
HQ	4 412	7 145	11 557	8 106	8 333	16 439	142.2%	8 105	6 199	14 304	87.0%	123.8%
Total	**12 213**	**13 479**	**25 692**	**13 970**	**10 051**	**24 021**	**93.5%**	**13 956**	**7 910**	**21 866**	**91.0%**	**85.1%**



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Infrastructure and logistics (ILS)

WHO objective(s)

To frame an enabling policy and create an institutional environment in order to support the timely implementation of WHO's programmes in Member States.

Indicator(s) and achievement

- *Appropriate, timely and effective use of resources and existence of reliable infrastructure and logistic support services at all organizational levels*. The delivery of infrastructure and logistic support services was commensurate with staffing and resource levels. Efforts continued to increase the effectiveness, improve the quality and rationalize the use of resources.

Main achievements

- WHO took occupancy of the new global service centre in Kuala Lumpur in late 2007.
- Development of the first capital master plan.
- Completion of several office extension, renovation and construction projects, including the WHO/UNAIDS building at headquarters.
- A net increase of 15% in the amount of reimbursable procurement on behalf of Member States was recorded compared to the previous biennium.
- Negotiation of a global contract for copying and printing services has generated significant savings.
- Negotiations with airlines for use of cheaper routes and pooling with sister agencies has generated significant savings in air fares globally.

Achievement of Organization-wide expected results

Infrastructure support services operated in a resource-effective and efficient manner

Indicator	Baseline	Target	Achievement
Average cost of selected operational transactions for general building management and office services	Average cost at end of 2004–2005 biennium	Not in excess of average cost in 2004–2005	Average cost of building maintenance contracts and selected operational transactions remained the same despite increased inflation. Cost saving measures included: renegotiation of maintenance contracts, introduction of energy saving measures, reduction of service levels and outsourcing of print and photocopying services

Fully achieved. Progress has been made in providing additional office space for staff while introducing environmentally friendly measures. The new WHO/UNAIDS building, for example, was constructed in a resource efficient manner using renewable energy. As a result of reviewing and reassessing services, offices have been able to make some efficiency gains and improvements in service quality. For example, in the Regional Office for the Western Pacific, the newly renovated and constructed facilities and the introduction of a reporting system for monitoring requests, repairs and preventive and corrective maintenance allows the available resources to be managed more efficiently. However, demands placed on services by increasing staffing levels on the one hand and static budgets on the other are a cause for concern.

Logistics support functions operated in a resource-effective and efficient manner

Indicator	Baseline	Target	Achievement
Average cost of selected logistics support functions for printing and distribution, travel and communications	Average cost at end of 2004–2005 biennium	Not in excess of average cost in 2004–2005	Reductions in the cost of air travel have been realized by the Regional Office for Africa. At headquarters, the number of fares negotiated with airlines has increased. Printing costs have been reduced by using external suppliers

Partly achieved. Efforts to reduce costs have been affected by the devaluation of the United States dollar, as well as rising inflation partly as a result of higher fuel charges. Through the renegotiation of contracts and more efficient ways of providing services, significant cost reductions have been realized in a number of areas, particularly printing and air travel. Staff shortages in some offices have threatened to undermine the provision of appropriate levels of service.

Global governing bodies and technical meetings provided with effective infrastructure and logistic services

Indicator	Baseline	Target	Achievement
Number of services that need to be refined	Number of services revised and adapted in previous year	Decrease in number of issues addressed and zero recurrence	There were fewer problems and no recurrence of major ones

Partly achieved. Support given to the governing bodies continues to be analysed for further improvement. Support includes venue and conference room preparation, interpretation, documentation, catering, travel assistance and hotel bookings. The limited capacity of meeting rooms in some offices, combined with an increase in the number of governing body meetings without any corresponding increase in budget, made it difficult to deliver the agreed level of service.

Health supplies of the highest quality at the best price procured for Member States and technical programmes

Indicator	Baseline	Target	Achievement
Increase in the proportion of direct procurement carried out using negotiated agreements (such as UN Web Buy)	Percentage of direct	10% increase in direct procurement	Depending on the office, increases of between 40% and 60% in the use of the WHO Web Buy catalogue have been realized compared to 2004–2005

Fully achieved. The biennium has seen a considerable increase in centralized procurement. As more long-term agreements are concluded and more essential items become available through WHO global catalogues, operational efficiencies continue to be achieved.

Security and safety of grounds and premises improved

Indicator	Baseline	Target	Achievement
Number of WHO sites that comply with minimum operating security standards	Complying sites as at end of 2005	All sites	It is estimated that 68% of offices comply with minimum operating security standards

Partly achieved. Although higher levels of compliance with minimum operating security standards have been achieved, the lack of a designated budget and associated funding for security expenditure remains a major impediment to progress.

Real estate facilities improved

Indicator	Baseline	Target	Achievement
Availability of an updated 10-year rolling master plan of real estate projects	Master plan of previous biennium	10-year rolling master plan adopted	The draft capital master plan 2008–2017 covering real estate projects in all major offices was adopted by the Sixtieth World Health Assembly
Proportion of projects implemented with financing from the Real Estate Fund that deviate from recognized best practice for local construction and environmental norms	Percentage of implemented projects that deviate from best practice at end of 2005	Less than 10% of implemented projects that deviate from best practice	Insufficient evidence to determine achievement value in relation to target

Partly achieved. Despite modest resource allocations, offices have begun work on necessary renovations. A number of office extension, renovation and construction projects have been completed, addressing the growing need for additional office space.

Lessons learnt and actions required to improve performance

Lessons learnt:

- Offices report a surge in last-minute service requests, as well as very short notice for organizing and servicing important events and meetings.
- It is expected that despite the efficiency measures, the cost of support services will rise as a result of inflation, the downward trend of the United States dollar exchange rate and the increase in oil prices.
- Outsourcing and off-shoring of services has proved to be a cost-effective means of reducing operational costs in some offices.
- Negotiations with major airlines and airline consortiums to extend preferential fare arrangements have continued to yield significant savings.

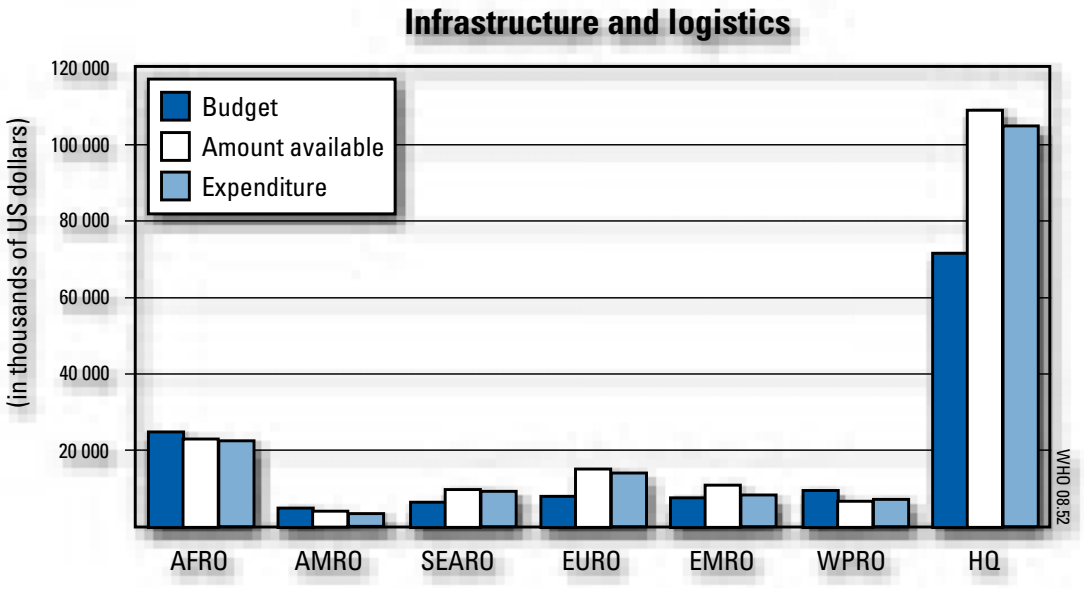
Required actions:

- The fixing and communication of agreed levels of service might engender more reasonable expectations.
- Service levels need to be adjusted to compensate for rising inflation and the downward trend of the United States dollar, and the changes made known.
- Further cost cutting through outsourcing and off-shoring of support services should continue wherever it is deemed cost-effective.
- Global negotiations should be pursued in other areas where they might reap dividends, as they did in case of travel agency services and photocopying.
- Negotiations with major airlines and airline consortiums to extend preferential fare arrangements should be continued and extended to include so-called second and third circle flights, namely those that originate outside Geneva but are paid for by headquarters and flights between other duty stations paid for by regional offices.

1 Resolution WHA60.12.

Financial implementation

Infrastructure and logistics												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	10 029	13 971	24 000	9 548	13 187	22 736	94.7%	9 548	12 891	22 439	98.7%	93.5%
AMRO	2 213	1 976	4 189	2 640	1 013	3 654	87.2%	2 593	1 013	3 606	98.7%	86.1%
SEARO	2 521	3 598	6 119	2 426	6 781	9 207	150.5%	2 426	6 772	9 198	99.9%	150.3%
EURO	5 637	1 642	7 279	5 651	8 980	14 631	201.0%	5 651	7 852	13 503	92.3%	185.5%
EMRO	5 315	1 664	6 979	4 070	5 833	9 903	141.9%	4 070	3 857	7 927	80.1%	113.6%
WPRO	4 789	4 190	8 979	4 190	2 508	6 698	74.6%	4 190	2 508	6 698	100.0%	74.6%
Sub-total Regions	**30 504**	**27 041**	**57 545**	**28 526**	**38 302**	**66 828**	**116.1%**	**28 478**	**34 893**	**63 371**	**94.8%**	**110.1%**
HQ	38 020	32 915	70 935	37 860	70 967	108 827	153.4%	37 831	66 445	104 276	95.8%	147.0% **
Total	**68 524**	**59 956**	**128 480**	**66 386**	**109 269**	**175 655**	**136.7%**	**66 309**	**101 338**	**167 647**	**95.4%**	**130.5%**



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** *Available resources and expenditure figures for headquarters include supply service trust funds, which are provided by Member States for WHO to carry out procurement on their behalf. These funds are not provided for the implementation of WHO programmes; they are not, therefore, reflected in the Programme budget figures. This explains the variation between budget and expenditure figures in several locations and in particular for headquarters.*

WHO'S CORE PRESENCE IN COUNTRIES (SCC)

WHO objective

To ensure the relevance and effectiveness of the Organization's work and its accountability to Member States through a core presence in countries based on WHO's strengths and adapted to the situation in individual countries as outlined in the specific country cooperation strategy; allocating technical and financial resources accordingly; and ensuring that country inputs guide WHO's policy and its technical and advocacy work.

Indicator(s)

- *Number of countries in which the Organization has a well-defined core presence with a workplan and the necessary resources for tackling priority issues as identified in the specific country cooperation strategy*. In all 147 countries where WHO has a country office its presence has been determined on the basis of the resources provided in the Programme Budget 2006–2007.

Main achievements

- Most (80%) country offices are now connected to the Global Private Network, which has greatly enhanced communication across the Organization.
- All regions have agreed to use a corporate competitive selection process for recruitment of heads of WHO country offices to amplify their capability.
- There is now a greater delegation of authority in some regions. There has also been agreement on further reviewing the delegation of programmatic and managerial responsibility to empower country teams.
- A 100% funding allocation from the corporate account was sent to regional and country offices to be used for strengthening their capacity.
- The Fourth Global Meeting of WHO Country Offices with the Director-General and Regional Directors was held at headquarters in 2007. This policy dialogue has led to institutionalization of the involvement of heads of country offices in the Organization's policy formulation process, and other key action points that are being followed up by the three levels of WHO.

Achievement of Organization-wide expected results

WHO offices maintained in countries

Indicator	Baseline	Target	Achievement
Number of WHO country offices	143	143	147[1]

Fully achieved. In some countries, sub-offices have also been established. In the European Region, a new WHO country office was opened in Montenegro. The WHO Country Presence 2007 survey report, based on a response rate of 100%, provides

[1] This includes both WHO country offices and special field offices, for example the United States – Mexico Border and occupied Palestinian territory field offices.

detailed information on WHO country and special offices, sub-offices, country office staffing and funding, the use of country cooperation strategies, and participation of WHO country teams in national development processes and the United Nations Country Team. Political unrest and instability were mentioned by some regions as impediments to effective programme implementation and functioning of country offices. In the Region of the Americas, a major transformation exercise in the Caribbean was the restructuring of the former Caribbean Program Coordination office located in Barbados and its conversion into two separate units operating from the same premises but with distinct missions and scope.

Improved WHO core presence and capability to implement WHO's strategic agenda at country level

Indicator	Baseline	Target	Achievement
Competitive selection processes for WHO Representatives and Liaison Officers	Selection process set up in one region	Selection process consistently applied in all regions	Four of the six regions applied region-specific competitive selection processes to recruit their heads of WHO country offices
Systematic reprofiling of WHO country teams in response to needs outlined in specific country cooperation strategies	Methodology for reprofiling of WHO country teams under development in selected regions	Reprofiling of WHO country teams as part of routine WHO managerial process in all regions	Methodology for reprofiling was finalized based on the experience of one region. Reprofiling in all regions was than carried out based on country cooperation strategies as approved in the Programme Budget 2006–2007. 2 regions finalized country office development guidelines, organigrams and human resource plans using country cooperation strategies as a framework
Proportion of WHO Representatives and Liaison Officers having participated at least once in the biennium in global reference groups and consultations	Proportion as given by survey at the end of 2005	25% increase (end of 2007 survey)	Systematic monitoring to assess the proportion of the increase in participation of WHO Representatives and Liaison Officers in global meetings and consultations did not take place
Introduction of programme implementation mechanisms to ensure consistent and coordinated technical support to countries across WHO levels and areas of work	Coordinated programme implementation mechanisms started in a few regions	Coordinated programme implementation mechanisms put in place in all regions	Regions have adopted different approaches, based on regional specificity, to coordinated and consistent technical support provided to countries. One region established an intercountry support team and another restructured its subregional offices to increase technical support to countries

Partly achieved. The terms of reference of heads of country offices were revised to reflect WHO's changing role at country level; they were approved by the global policy group. All regions agreed to use a corporate competitive selection process for recruitment of heads of WHO country offices to enhance their capability.

WHO's policy on country presence, developed under the guidance of Deputy Programme Managers, is part of the country focus road map aimed at enhancing the competencies and skills of country teams. Capacity in country offices has been strengthened to deal with partnerships, alignment and harmonization, and United Nations reform. The alignment and harmonization learning toolkit was field tested in three countries and is being rolled out in a phased manner from 2008 onwards. A United Nations reform country support team has been established to assist WHO country teams involved in United Nations reform in pilot countries. Important information on, and feedback from, countries is being shared through a bulletin and dedicated share point.

Harmonization for Health in Africa was established to enable staff from WHO head-

quarters and regional offices and partners in related fields to work together with national counterparts in 14 countries to promote programmatic coherence at country level. The Regional Office for the Americas/PAHO decentralized 42 posts and redeployed the human resources to country offices to strengthen WHO's core presence and its capacity to implement the country cooperation strategy's strategic agenda in country offices. The Regional Office for Africa established an intercountry support team with a view to increasing the responsiveness of country offices to identified local needs. The delegation of authority to heads of country offices increased in some regions. In the Regional Office for Europe, they were made first level supervisors of technical field staff and given a leading role in the selection of national professional officers. It took longer than anticipated to reach consensus on a proposal for the competitive selection of heads of country offices. Although two regions systematically undertook reprofiling exercises defining country presence in accordance with the country cooperation strategy, resource constraints hampered further scaling up of the reprofiling exercise to cover all regions.

Country cooperation strategies developed and updated and used as a basis for planning the Organization's country work

Indicator	Baseline	Target	Achievement
Number of country cooperation strategies aligned with national objectives and plans, and articulated with United Nations and other development agencies' platforms and processes at country level	133[2]	143, including 25% reviewed/updated	148 including more than 30% reviewed/updated
Application of a common system of joint planning for developing a single plan and budget based on the country cooperation strategy	Common approach being developed based on regional experiences	Common system applied in all regions	Design of the global management system recognizes the concept of a "one country" plan. It will be implemented with the global management system in the next biennium

Fully achieved. Although progress was made in institutionalizing the country cooperation strategy within WHO, it will need to be closely monitored to ensure its core principles and features are complied with across the Organization, in particular in relation to the aid effectiveness agenda as promoted in the 2005 Paris Declaration. Country cooperation strategy activities have taken place throughout the biennium to improve alignment with national priorities and harmonization with the United Nations Development Assistance Framework and other partnership platforms. Country offices are using country cooperation strategies for developing their workplans with regional offices, readjusting their competencies and skills, advocating for WHO's priorities, and mobilizing resources. A new country cooperation strategy guide is being prepared to improve the quality, as well as use, of country cooperation strategies.

The concept and practice of joint planning for a "one country" plan is now reflected in the operational planning guidelines. However, there are still challenges in applying a corporate mechanism for joint planning across the entire organization, mainly arising from a lack of compliance with the guidelines, and uncertainty about the nature of the contribution of headquarters to the "one country" plan. Although planning across the Secretariat for a single WHO country plan and budget in all countries is not yet a reality, a methodology to systematically map country cooperation strategy priorities with the strategic objectives and organization-wide expected results of the medium-term strategic plan has been devised by the Country Support Unit network to ensure the country cooperation strategy – individually and collectively – guides operational planning at all levels of the Organization.

[2] Including country cooperation strategies for the Organisation of Eastern Caribbean States and the 14 states and areas covered by the WHO Representative in the South Pacific.

Mechanisms for effective implementation and monitoring of WHO country focus and decentralization policies strengthened

Indicator	Baseline	Target	Achievement
Availability of WHO management information for the country focus policy, including a core set of performance indicators for WHO at country level	Management information system for country focus designed	Management information on country focus produced and disseminated across the Organization	The Country Support Unit network has been instrumental in facilitating implementation of the country focus policy and strategies, as well as monitoring progress and sharing information, through the Country Focus Annual Reports (in three languages), the country focus web site (available in four languages) and the Country Support Unit network portal
Continuous sharing of best practices through meetings of WHO Representatives and Liaison Officers	One Organization-wide meeting, and, in each region, at least two regional meetings per biennium	One Organization-wide meeting, and, in each region, at least two regional meetings per biennium	The Fourth Global Meeting of Heads of WHO Country Offices with the Director-General and Regional Directors. All heads of country offices also participated at least once a year in their regional meetings to share best practices
Effective network of WHO country support units with participation from all levels of the Organization	Functions of the Country Support Unit network carried out as indicated in the 2004 report of the network[3]	All functions of the network effectively carried out	Effectiveness of Country Support Unit network contributed to several important Organization-wide developments, including strengthening of country support function
Level of satisfaction among WHO Representatives and Liaison Officers with the technical support and back-up from regional offices and headquarters for their country cooperation strategies	Results of the first qualitative survey on level of satisfaction of WHO Representatives and Liaison Officers (end 2005)	25% increase in level of satisfaction as measured by the second qualitative survey (end 2007)	Based on the results of the surveys, there was no significant change in the level of satisfaction among WHO Representatives and Liaison Officers with the technical support and back-up from regional offices and headquarters between the two bienniums measured

Partly achieved. The country focus policy and strategies were monitored through the Country Support Unit network portal and the progress made was reported in the 2006 and 2007 annual reports. The Country Support Unit network met on four occasions to share information, to review progress made in the implementation of the country focus policy and to build consensus on some key priority actions. One of the meetings was a joint meeting of the Community Support Unit and planning officers networks, at which a common agenda, including joint planning, a "one country" plan based on the country cooperation strategy, and articulation of the strategy with the WHO managerial framework, was discussed. Implementation of WHO's collaborative programmes with countries was monitored on a regular basis in the Regional Office for Europe by the Country Operations Management Support Programme and Country Work Help Desk, and in the Regional Office for the Americas/PAHO. The outcome of regional heads of country offices' meetings contributed to identifying implementation gaps and led to corrective measures being taken to improve WHO's performance at country level. The introduction and application of the Country Activity Management System in countries in the Eastern Mediterranean Region improved efficiency in country offices in the Region and provided a bridge for understanding and implementing the global management system.

Despite these achievements, adequate technical and managerial support for countries, which is critical for improving WHO's performance, is still uneven between regions

[3] Country Support Unit Network 2004, Geneva, World Health Organization, 2005.

and insufficiently robust at headquarters. Some regions have started to work on an approach to reviewing cooperation at country level. Two country studies were conducted in 2006–2007 and more are planned for 2008–2009. A methodology is being developed on the nature of WHO's involvement in each country cooperation strategy cycle.

Lessons learnt and actions required to improve performance

Lessons learnt:

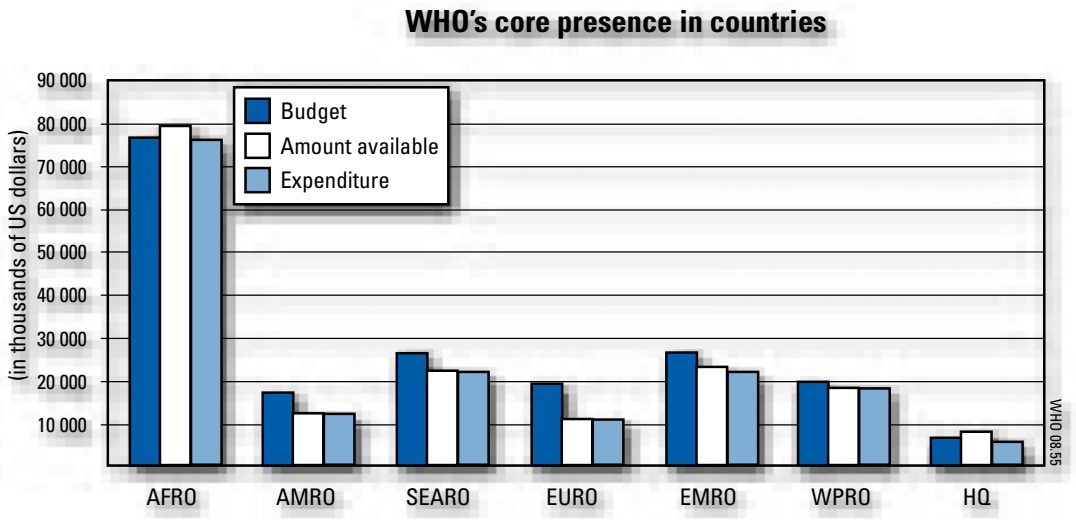
- A proper knowledge and understanding of individual countries and their strategic health needs and priorities are essential prerequisites for collaboration with countries.
- The country cooperation strategy process provides a platform for technical cooperation by bringing all levels of the Organization, as well as other health stakeholders, together for a coordinated response to countries' needs.
- Country cooperation strategies have proved useful in preparing medium-term strategic plans and operational plans.
- WHO's core presence in countries should be boosted and its credibility enhanced by building the capacity of heads of country offices and country office teams on the basis of need, as well as by reallocating human resources to country offices.
- WHO must have a professionally and administratively strong presence in countries in order to encourage collaboration and effective coordination and communication with national authorities and other health actors, and bring together all levels of the Organization.
- Joint planning between the three levels of WHO and across programmes increases trust and fosters collective commitment to organization-wide goals and objectives as expressed in the Fourth Global Meeting of WHO Country Offices with the Director-General and Regional Directors.
- In the context of the new aid environment, working with development partners, particularly United Nations partners, while supporting countries in their efforts to meet the health-related Millennium Development Goals, is the way to achieve results.

Required actions:

- To continue to foster and monitor the implementation of the country focus policy using the country focus roadmap.
- Formal endorsement, dissemination and follow-up of country cooperation strategies across the Secretariat is required to fully realize the inherent benefits of those strategies in countries.
- Country cooperation strategies should guide strategic planning at all levels of the Organization.
- The development or renewal of country cooperation strategies should be linked to United Nations Development Assistance Framework actions in countries, as well as national workplans and country office reprofiling, to ensure an appropriate and adequate country presence.
- Priority should be given to training WHO country office teams to deal with partnerships and the alignment and harmonization agenda, including reform of the United Nations Resident Coordinator System.
- The performance review of WHO's country work needs to be further developed.

Financial implementation

WHO's core presence in countries												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	63 515	13 065	76 580	70 804	8 299	79 103	103.3%	70 730	5 153	75 883	95.9%	99.1%
AMRO	11 702	5 173	16 875	11 459	1 056	12 515	74.2%	11 420	802	12 222	97.7%	72.4%
SEARO	18 636	7 437	26 073	17 298	5 166	22 464	86.2%	17 298	4 623	21 921	97.6%	84.1%
EURO	8 487	10 398	18 885	9 089	2 291	11 380	60.3%	9 089	1 802	10 891	95.7%	57.7%
EMRO	11 701	14 613	26 314	11 906	11 264	23 170	88.1%	11 906	10 264	22 170	95.7%	84.3%
WPRO	11 478	7 848	19 326	11 625	6 686	18 311	94.7%	11 625	6 344	17 969	98.1%	93.0%
Sub-total Regions	**125 519**	**58 534**	**184 053**	**132 181**	**34 761**	**166 942**	**90.7%**	**132 068**	**28 988**	**161 056**	**96.5%**	**87.5%**
HQ	3 105	3 445	6 550	2 984	4 999	7 983	121.9%	2 984	2 770	5 754	72.1%	87.8%
Total	**128 624**	**61 979**	**190 603**	**135 165**	**39 760**	**174 925**	**91.8%**	**135 052**	**31 758**	**166 810**	**95.4%**	**87.5%**



* *Amount available figures are not represented as such in the Financial Report and Audited Financial Statements, but include elements of both income received during 2006-2007 and amounts carried forward from the opening fund balances at 1 January 2006.*

Human resources management in WHO (HRS)

WHO objective(s)

To provide the strategic direction, policies and procedures necessary for ensuring that human resources services are delivered in a timely and effective manner in support of WHO's role of promoting and protecting health.

Indicator(s) and achievement

- *Operational excellence in the timely delivery of high-quality human resources services at headquarters and in regional and country offices*. Headquarters and regional offices have developed and implemented the necessary policies and procedures for facilitating the provision of quality services to staff and management across the Organization.

Main achievements

- Support was provided for the global service centre, as well as for post classification, recruitment and outreach, career development, and review of pay and benefits.
- Delivery has been improved in the following areas: the fast track selection process, e-testing and enhancement of e-tools, the grouping of similar positions in different programmes for recruitment purposes; and the development of human resources planning under the global management system.
- The framework of revised contractual arrangements was approved by WHO governing bodies and has been implemented.
- The electronic version of the Performance Management and Development System has been modified to include both staff competencies and plans for individual staff development. It is being used by all fixed-term staff at headquarters and is also being piloted in two regions.
- The range of learning and development opportunities in support of the core competencies has been extended through the addition of courses in managing diversity, conducting difficult conversations, self awareness and management, and effective communication. Distance learning programmes enabled staff in country offices to take part in more programmes. In addition, training for specific categories of personnel, for example administrative assistants, has been broadened to include behaviour and competencies beyond the knowledge and skills involved in administrative processes.

Achievement of Organization-wide expected results

New global human resources information system and streamlined, re-engineered procedures established, providing staff globally with improved quality and quantity of information and better access

Indicator	Baseline	Target	Achievement
Availability of internally consistent global information across offices	Lack of internally consistent human-resources information throughout the Organization	Human resources module of the global management system implemented and operational	As the global management system is not yet operational, the human resources module has not been implemented
Degree to which organizational units can be reprofiled and analysis of gap between required and available skills and competencies can be undertaken	Reprofiling limited due to lack of tools and information	All organizational units using reprofiling tools and skills-gap analysis	Approximately 80% of organizational units made use of reprofiling tools and/or skills gap analysis

Partly achieved. Access to e-tools has improved and their design enhanced in anticipation of the launch of the global management system. The human resources e-Guide was updated, inter alia, to facilitate consistent application of rules and procedures. The policies and procedures underpinning the global management system were drafted and sent to the Global Staff Management Council and the Office of the Legal Council for clearance. As part of the strategic direction and competency review exercise, headquarters and regional offices provided support for designing organizational and functional structures, for funding duty travel and participation in Organization design exercises, and for briefing staff on the consistent application of reprofiling tools and skills-gap analysis. In 2006, some 470 fixed-term posts were created as a result of the strategic direction and competency review exercise. To accelerate the recruitment process for types of post for which the use of generic post descriptions would be appropriate, rosters of pre-qualified candidates were compiled and testing and initial interviewing were performed centrally. The regional and country offices have been doing the same. Functions that have traditionally been carried out by staff on temporary contracts, and for which a continuing need has been identified, are being assigned to newly established posts. A compendium exercise has also been carried out at headquarters involving the reprofiling of posts and subsequent matching of staff. A planning tool has been developed to ensure that human resources forms an integral part of the whole operational planning process, and a temporary spreadsheet has been designed for downloading information directly into the global management system. This tool will also be used in the production of a human resources assessment plan for managers to facilitate their work. Human resources staff have participated in the design and testing of human-resources related applications, reporting and review processes within the global management system. E-recruitment has also been updated and enhanced and improved security features have been added.

Effective learning programmes that meet staff and organizational needs launched, ensuring the effective use of individual development plans across the Organization

Indicator	Baseline	Target	Achievement
Level of staff satisfaction with development opportunities offered at WHO	Limited number of development opportunities	Expanded availability of learning programmes based on assessed demand	The range of learning and development opportunities in support of the core competencies has been extended
Level of satisfaction with management and leadership capacity at WHO reported by staff	Limited leadership and management learning programme available	Leadership and management learning programme implemented for all senior and middle managers	Following the participation of 400 top managers in the Global Leadership Programme, staff perceptions of managers' effectiveness increased from 38% to 44%. In 2007, 66% of staff rated their supervisor as a good team leader compared with 57% in 2005

Partly achieved. A policy of investing in learning and development that supports a balanced approach to technical skills, leadership, management and administration, core competencies, and induction of new staff has been formulated and put into practice across the Organization. Although all areas were covered, the development of technical skills varies considerably and a more strategic and systematic approach is necessary. Similarly, while a range of development opportunities is available, staff in country offices need better access to them. The Organization will continue to invest in innovative ways of effectively delivering distance learning with a view to providing more equitable access. During the biennium, one in eight staff members enrolled for courses in the WHO official languages. The uptake of learning opportunities varies considerably: women tend to be more engaged than men, and participation tends to decline as grade and responsibilities increase. The development and training opportunities offered by the Organization need to anticipate the desired impact on the achievement of stated objectives. This will require a restructuring of training opportunities and more careful investment in individuals and teams. Staff satisfaction with development opportunities increased between 2005 and 2007 according to the WHO leadership and management survey. Personal development plans have been introduced for 65% of staff compared to 57% in 2005, and 55% of managers now encourage learning compared with 51% in 2005. Supervisors offer coaching to improve skills and 35% of staff believe that WHO is investing in the development of its human resources compared with 29% in 2005.

The Global Leadership Programme was designed to improve the capability of WHO managers to lead and manage. Before the Programme was introduced, a survey was designed to evaluate its impact by measuring the perceptions of staff worldwide about the actions and behaviour of their managers. The survey was conducted again after 400 of the most senior managers with responsibility for financial and human resources throughout the Organization had participated in the Programme. Some 30 more than originally foreseen took part after the Programme was expanded to include middle managers with significant responsibilities. The Programme was shown to have had a positive impact on staff perceptions of WHO managers at all levels of the Organization. While direct causality cannot be proved, the survey demonstrated statistically significant increases on most measures. But despite increased satisfaction, much remains to be done: sustaining the Programme in 2008–2009, and ensuring that new entrants to the management ranks take part in it and that a broader range of middle managers are given similar opportunities. The evaluation also revealed weaknesses in certain aspects of leadership and management that need to be better addressed either through the Programme or other means, for example increasing investment in human resources and rewarding those who develop their skills and competencies.

Rotation and mobility system fully implemented, based on a compendium of vacancies issued at least once a year

Indicator	Baseline	Target	Achievement
Proportion of staff having completed their maximum standard assignment length who participate in the rotation and mobility programme	Limited voluntary rotation and mobility	80%	The Director-General decided that the introduction of a global mobility scheme should be deferred to 2008–2009

Deferred. A rotation and mobility policy was agreed in the Global Staff Management Council and approved by the Director-General, but implementation has been deferred. Of the international positions in the global service centre, 70% have been filled by internal candidates who were willing to move. The impact of mobility on staff and families continues to be reviewed as part of the strategy on staff rotation and mobility. WHO is an active member of the United Nations Secretary-General's initiative to support the employment of expatriate spouses.

Conditions of service improved and staff-friendly policies implemented; WHO pay and benefits system brought into line with the United Nations field-oriented organizations' system

Indicator	Baseline	Target	Achievement
Degree of improvement in staff-friendly policies	Special-operations living-allowance policy not applied; lack of a post-traumatic stress disorder programme and global counselling services	Implementation of special-operations living-allowance policy; post-traumatic stress disorder and stress management programmes in place	Amendments to Staff Rules have been implemented covering the following: mobility and hardship allowance policy and procedures, domestic partnership policy, paternity leave, an additional four weeks' maternity leave for multiple births, and gender equal adoption leave. Staff Rules have also been amended based on International Civil Service Commission's recommendations relating to: remuneration of staff in the professional and higher categories, salaries of staff in ungraded posts and the Director-General's salary. Contract reform and the principle of job and pay equality has also been approved and implemented

Fully achieved. HIV/AIDS orientation interactive learning sessions have been organized in order to increase staff awareness, knowledge and competence with regard to HIV/AIDS in the workplace. Contract reform was implemented on 1 July 2007 and covers: conversion to continuing appointments after completion of a minimum of five years uninterrupted active service on a fixed-term contract and certified satisfactory performance; continuing appointments for those coming under certain contractual criteria on 1 July 2007; temporary appointments of up to two years; and fixed-term appointments of one year with the option to extend for up to five years. New and improved conditions of employment for locally and internationally recruited temporary staff have been introduced covering, dependency allowances, staff health insurance, within-grade-increases, language allowances, hazard pay, maternity leave, paternity leave and adoption leave. New and improved conditions of service for internationally recruited temporary staff irrespective of duration of contract have also been introduced including, assignment grants, relocation grant lump sums, education grants, education grant travel, hardship allowances and improved entitlements.

Procedures and systems maintained, enabling the Organization to recruit staff and meet its contractual obligations as an employer, while providing a caring and supportive environment for all staff

Indicator	Baseline	Target	Achievement
Proportion of timely and correct replies to queries and requests for assistance, and payments to staff and retirees according to their respective compensation/benefits package in accordance with entitlements rules	As per survey at end of 2005	100%	Approximately 75%
Frequency of appeals for non-compliance with the Organization's regulatory instruments	Completed survey on organizational climate	Improved yearly survey results	Appeals increased from 41 in 2006 to 45 in 2007

Partly achieved. Procedures and systems have been maintained and improvements introduced. However, there has been an increase in the number of appeals. It is expected that these will decrease with the implementation of contract reform and improved selection procedures.

Reliable staff security management systems in WHO in place to enable the effective and efficient conduct of activities while ensuring the security, safety and well-being of staff

Indicator	Baseline	Target	Achievement
Percentage of WHO staff in headquarters and regions performing country duties who are adequately trained in United Nations security management procedures and personal security	95% of staff who travel to or are assigned to countries in security phase trained in basic security in the field	100%	It is estimated that 99% of staff in headquarters, countries and regions have passed the basic test and 80% have passed the advanced test
Percentage of country offices that are equipped in conformity with the minimum operating security standards	50% of countries minimum operating security standards compliant	80%	75%

Partly achieved. According to the survey results, 68% of offices, 75% of country offices and 27% of vehicles comply with the minimum operating security standards. In the wake of the terrorist attack on the United Nations office in Algiers, minimum operating security standards will be reinforced in many countries, thus entailing additional costs that have not been budgeted for.

Lessons learnt and actions required to improve performance

Lessons learnt:

- Training software for the global management system required more human and financial resources than originally foreseen.
- Implementation of a rotation and mobility system at a time of great organizational change should have been avoided.
- Before introducing changes in conditions of service that require a cultural shift in an organization with such a wide geographical representation, extensive consultations should be held on such matters as domestic partnership policy and paternity leave.

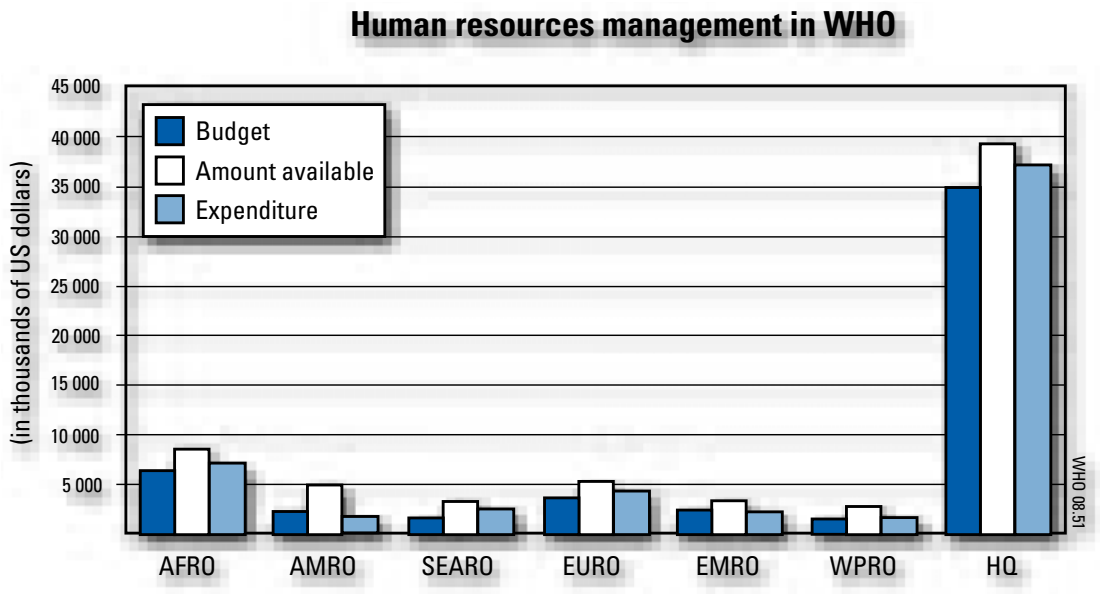
- The detailed procedures preceding implementation of contract reform, as well as certain transitional measures, required additional unplanned investment in time and resources to ensure an effective communication and training strategy.
- The introduction of changes in the conditions of service, accompanied by the reorganization of structures and introduction of an enterprise resource planning system would have benefited from more staff. Changes should be phased in gradually in order to allow a large number of contractual transactions to be processed.

Required actions:

- Implementation of a rotation and mobility system should be postponed until 2009.
- Enough time should be allowed for consultations to be held on major changes in human resources policy and practices.
- Departments providing support services should improve their human resources planning to anticipate rises in demand.
- Each region should report annually on its progress towards completing security tests.
- Directors of Administration and Finance and WHO Representatives should be regularly briefed on security training and minimum operating security standards, including the associated financial implications.

Financial implementation

Human resources management in WHO												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	2 287	4 113	6 400	2 177	6 291	8 467	132.3%	2 103	4 978	7 081	83.6%	110.6%
AMRO	872	1 205	2 077	999	3 797	4 796	230.9%	954	790	1 744	36.4%	84.0%
SEARO	826	774	1 600	724	2 517	3 241	202.5%	724	1 640	2 364	72.9%	147.8%
EURO	2 644	956	3 600	2 904	2 218	5 122	142.3%	2 904	1 244	4 148	81.0%	115.2%
EMRO	980	1 257	2 237	1 071	2 347	3 418	152.8%	1 071	944	2 015	58.9%	90.1%
WPRO	733	651	1 384	659	2 028	2 687	194.2%	660	799	1 459	54.3%	105.4%
Sub-total Regions	**8 342**	**8 956**	**17 298**	**8 534**	**19 198**	**27 732**	**160.3%**	**8 416**	**10 395**	**18 811**	**67.8%**	**108.7%**
HQ	14 042	20 533	34 575	13 033	26 017	39 050	112.9%	13 028	23 991	37 019	94.8%	107.1%
Total	**22 384**	**29 489**	**51 873**	**21 567**	**45 215**	**66 782**	**128.7%**	**21 444**	**34 386**	**55 830**	**83.6%**	**107.6%**



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Knowledge management and information technology (KMI)

WHO objective(s)

To promote an organizational culture supported by an information technology infrastructure that responds to the needs of users in Member States and within the Organization related to knowledge management and information technology.

Indicator(s) and achievement

- *Adequacy of needs-based knowledge management programmes in health systems in Member States and throughout the Organization*. Knowledge sharing and management increased across WHO and externally through the widespread implementation of communities of practices, and the increased dissemination of WHO and other information products through the web site and other means in multiple languages.
- *Availability of an appropriate and cost-effective information and communication technology infrastructure that meets the needs of users throughout WHO*. Technology infrastructure advances at country, regional and global level have made telecommunication services and core computing capability available across the Organization. This, in turn, has led WHO to reconsider its internal communications and operations.
- *Effective implementation of the Organization-wide global management system*. The global management system is based on a comprehensive range of designs. Staff have worked extensively both to validate these designs and to prepare the Organization for the system to be implemented in 2008.

Main achievements

- The global information and communication technology strategy has been finalized and released.
- The majority of staff across the Organization were linked by telephone and the Internet through the Global Private Network.
- Designated teams have helped to develop the information and telecommunication technology programme for the global management system.
- The Global Index Medicus, established under the auspices of WHO regional offices, gives access to bibliographical information and some locally published health material. Knowledge sharing tools, such as communities of practice, exist in most regions.
- The Health InterNetwork Access to Research Initiative and its two sister programmes provided free access to medical, environmental, agricultural and nutritional online information to some 4500 institutions in over 100 Member States. New web sites were created for country offices, mainly in the African Region, the Region of the Americas, and the Eastern Mediterranean and European Regions. A web policy was established in the European Region.

- A publishing policy was formulated in the regions and at headquarters. A publishing policy and procedures working group was established to review, monitor and standardize publishing policies across the Organization. The marketing and dissemination of health information products remained priority activities. A plan of action to promote multilingualism across the Organization was submitted to Executive Board.

Achievement of Organization-wide expected results

Knowledge management policies and strategies developed to enable learning in health systems and in the Organization

Indicator	Baseline	Target	Achievement
Availability of effective policies, practices, toolkits and training for knowledge management in Member States and the Organization	Policies, toolkits and training for knowledge management available in some offices	Access to effective policies, practices and toolkits by target health systems and the entire Organization; most target countries engaged in their development	Policies and strategies on knowledge management have been developed and disseminated at headquarters and in some regions where capacity building has started in country offices. A draft comprehensive eHealth framework and a framework for the development of information and communication technology and eHealth policies at national level were prepared
Existence of communities of practice to foster managerial and programmatic effectiveness	Some communities of practice supported within the Organization	Thriving communities of practice in target health systems and throughout the Organization	A community of practice portal was launched; facilitation guidelines have been drawn up; and some communities of practice have been established at regional and national level

Partly achieved. The first Global Observatory for eHealth report was published. Country profiles are now nearing completion and will soon be published by regional offices. To guide the provision of technical support to Member States, a Knowledge Systems in Health survey was conducted in which 42 countries participated. A better reporting system was devised to record travel undertaken, consultants employed and lessons learnt. An automated designation system for collaborating centres was implemented that improves both transparency and the accessibility of information to stakeholders. New networks of collaborating centres became operational and have begun work on a strategy for peer-to peer communication. A community of practice portal was launched, which provides easy access to thematic communities inside WHO and among its partners. There has been effective collaboration between technical programmes and WHO country offices, but inadequate human and financial resources have hampered the drawing up of regional and national norms and standards for knowledge management.

WHO's information products and health information and communication technology seamlessly integrated into learning systems

Indicator	Baseline	Target	Achievement
Extent of use of custom-organized interfaces for sharing information	Suboptimal use of interfaces for sharing information	Better use of knowledge-sharing environments	Following their adoption and use on a global scale, a wide range of modern information tools are now an integral part of WHO's working methods and are crucial to the delivery of its programmatic work. SharePoint, a document management system, as well as virtual-meeting tools, on-line workshops and survey tools are routinely employed to improve the effectiveness of WHO's work, although their use still remains limited
Proportion of staff who contribute to and benefit from the collective knowledge pool	Vertical knowledge sharing within the Organization	Knowledge sharing across institutional boundaries	All staff have benefited from the posting of relevant information products on the Internet and intranet. In some country offices, however, staff have not benefited from certain aspects of knowledge sharing

Partly achieved. New initiatives, such as the Africa Health Infoway and Sharing eHealth Intellectual Property for Development, were launched in several countries. The WHO regions have been active in providing access to public health information and knowledge from internal and external sources. Web sites across the Organization have been developed, updated and maintained. Knowledge sharing networks have been established in the regions, although additional training in their use is still needed.

Unified information management and technology architecture at WHO designed and implemented

Indicator	Baseline	Target	Achievement
Percentage of key documents used by the Organization for decision-making that are captured, organized and stored electronically	Most current (but not less recent) documents captured and accessible electronically	All key documents captured, organized and stored electronically	An Organization-wide data model and data dictionary for key corporate applications has been designed, developed and tested as part of the process of implementing the global data hub and global management system. SharePoint has been widely used, and the Regional Offices for the Eastern Mediterranean and South-East Asia have made progress in storing and accessing key documents digitally
Degree of commonality of standards for information and communication infrastructure, across all WHO locations	Base standard of compatible technology components available, founded on informal agreements	An agreed set of standards and products to meet business requirements for information compatibility, enable sharing of expertise, and achieve economies of scale	Libraries in the Regional Office for South-East Asia and in six country offices are using common standards for information management and sharing. WHO's global data hub, which takes effect in 2008 with the launch of the global management system, has established standards for information compatibility. The Regional Office for the Americas has concluded an agreement on alignment with the global management system

Partly achieved. Despite good progress in developing the global management system, it will not be implemented until 2008. The efforts of the designated information technology leadership team, coupled with robust standard setting and project management, has made it possible for the information technology services to prepare the infrastructure, data, applications and human resources for implementation of the new system. Despite being global in nature, the Global Private Network and global management system have been designed in a way that should improve the running of the Organization.

Appropriate technology infrastructure and information strategies in place to meet the business requirements of functionality, reliability and cost-effectiveness

Indicator	Baseline	Target	Achievement
Reliability of access to information technology systems and information content	Most WHO locations linked through a single supplier	Demonstrated competitiveness of communications networks, compared to industry standards and agreed business requirements	Computer systems have been maintained at high availability levels to meet user needs throughout WHO
Adequacy of information technology systems and information content at country level	Variable levels of information technology infrastructure and service at country level	Strengthened to meet a common service level	Country Offices have been connected by telephone and Internet with the rest of WHO, and video conferencing is widely used throughout the Organization. Low bandwidth collaboration tools have also been introduced in the regions. The Regional Office for South-East Asia upgraded its regional information and communication technology infrastructure to ensure availability and meet user needs. Four Eastern Mediterranean countries have been connected to the Global Private Network, and a local area network infrastructure has been implemented in all countries

Partly achieved. Increased networking between regional offices, country offices and headquarters has reinforced cooperation. WHO's Global Private Network has provided once disparate parts of the Organization with better access to interconnected telephone and internet systems. However, the reliability and cost effectiveness of these systems needs to be improved. Increased investment in information communication technology infrastructure and the growing complexity of using the products are leading to greater demand from countries for assistance, however, it will take time to make the necessary changes within WHO. The difficulties in consolidating technologies arise because vendors tend to lack true global presence. Furthermore, the ownership of solutions creates costs that need to be continuously challenged to ensure the ongoing viability of the technology. There should also be more professional staff in regional information technology teams to avoid disrupting management continuity. Good communication between staff members is vital to WHO's work, which necessitates having access to reliable information communication technology infrastructures and services, as well as adequate financial resources, particularly at country level.

WHO's information products and tools for using electronic information applied effectively and efficiently to address health issues in countries

Indicator	Baseline	Target	Achievement
Accessibility of frameworks and tools to make it possible to apply relevant information, including electronic, in support of health care in countries	Limited availability of frameworks and tools in countries for applying information	Frameworks and tools accessible and available for all priority WHO work in countries	A number of frameworks and tools have been made available through global, regional and country office web sites, libraries and documentation centres. Project-based initiatives, such as the Health InterNetwork Access to Research Initiative, and regional versions of the Index Medicus, have been introduced in regions and countries
Cost-effectiveness of the use at country level in support of health care of available information products and tools for use of electronic information	Suboptimal adoption and use of available information products	Greater adoption and more consistent use of available information products through training, outreach and cross learning	Open-source information management and dissemination tools – those for which users do not have to pay – were used by some regions and headquarters to achieve greater cost effectiveness

Partly achieved. A wide range of infrastructure related issues were addressed at headquarters and across the regions. In addition, an Index Medicus was compiled in the Western Pacific Region to provide access to health information originating from Member States, which is published in local medical journals but not included in international indexing services. In the Region of the Americas, training in the use of the Virtual Health Library software platform was provided for staff working at BIREME, a WHO/PAHO supported foundation that makes health information in Portuguese and Spanish available on line. In the Eastern Mediterranean Region, the Arabization of Health Sciences Network produced five books in Arabic.

Selected priority information products in relevant languages from headquarters and regional offices appropriately generated, disseminated and archived

Indicator	Baseline	Target	Achievement
Availability of information in relevant languages and in collaboration with regional offices	Most information products available in selected official languages	Priority information products available in most commonly spoken languages in countries	Headquarters arranged 178 translation agreements in 37 languages with 40 countries; 19 reprint agreements were signed with external publishers; and The world health report 2007 was published in all six official languages
Number and distribution of visits to, and downloads from, WHO's web site	Over 2.5 million visits and 2 million downloads per month	Over 4 million visits and 3 million downloads per month	Use of web sites increased across the Organization. Combined monthly visits total 4 million per month and there are 3.9 million page views per month
Impact of WHO information products, as measured by citations in scientific literature, reviews, or mentions in the media	Impact consistent with broad coverage by global media and international research literature	Impact indicates more directed use in Member States through priority institutional initiatives	Over one million print copies of WHO titles with international standard book numbers (ISBN) were distributed. Distribution has expanded through the establishment and continuation of the Global Health Library platform, the Global Index Medicus and the Western Pacific Index Medicus. Over 3000 requests for permission to use WHO materials, including text, images, figures, tables and logo, and 1600 requests for copies of European Regional Office information products were received during 2006–2007

Fully achieved. Numerous translations of priority titles were produced and web content has been expanded across the Organization. Demand from countries and local partners has been the driving force behind many interventions and adequate staffing levels will be essential for ensuring their effectiveness in the future. The Regional Office for Europe published nine priority titles in one, two or four languages and key technical documents have been prioritized for translation into local languages. The Regional Office for Africa generated and disseminated statutory and technical documentation in the three official languages of the African Region. All four official languages in the Region of the Americas received support through corporate information telecommunication technology systems. The Regional Office for the Eastern Mediterranean produced 138 publications in Arabic, English and French and issued 12 contracts for editing in English. In 2007, it issued 73 contracts for translating books and documents and printed and distributed two documents for the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases. It also translated abstracts of the *Bulletin of the World Health Organization* and the *Eastern Mediterranean Health Journal*, and published 12 issues of the latter.

Cost-effective provision of existing technologies to the Organization

Indicator	Baseline	Target	Achievement
Availability of corporate applications, supporting both health technical functions and administrative support functions, according to established business-service requirements	Continuity strategies limited, Varying levels of systems availability and support, inconsistent with the business need	Compliance with agreed information technology service levels (including service continuity plans) funded and implemented to meet current business requirements in terms of security, accuracy and usability	Support to administrative applications was reduced and the corresponding resources reallocated to the global management system

Partly achieved. Corporate and regional applications have remained fully available even while being adapted in readiness for the launch of the global management system.

Core programmes sustained with appropriate streamlined business processes and control mechanisms; fully operational global management information system in place that facilitates the Organization's performance and can be scaled to the size of each WHO office

Indicator	Baseline	Target	Achievement
Availability of global information for managerial and administrative purposes	Information available locally in fragmented form	Comprehensive, timely information available electronically	All current legacy systems remained fully available while new projects proceeded in parallel
Level of required reconciliation of administrative data	Fragmented information systems that require manual reconciliation	Reconciliation eliminated	The current standards for reconciliation within WHO (both manual and electronic) have remained in place and have been fully supported while the new system has been under development. Core programmes have been sustained and streamlined processes implemented, however, the full extent of their impact on operational performance will not be felt until the global management system is implemented in 2008

Partly achieved. By fully utilizing the increasingly comprehensive information technology framework, users have more effective tools at their disposal, although they

will only reach their full potential when the global management system has been implemented in 2008.

Lessons learnt and actions required to improve performance

Lessons learnt:

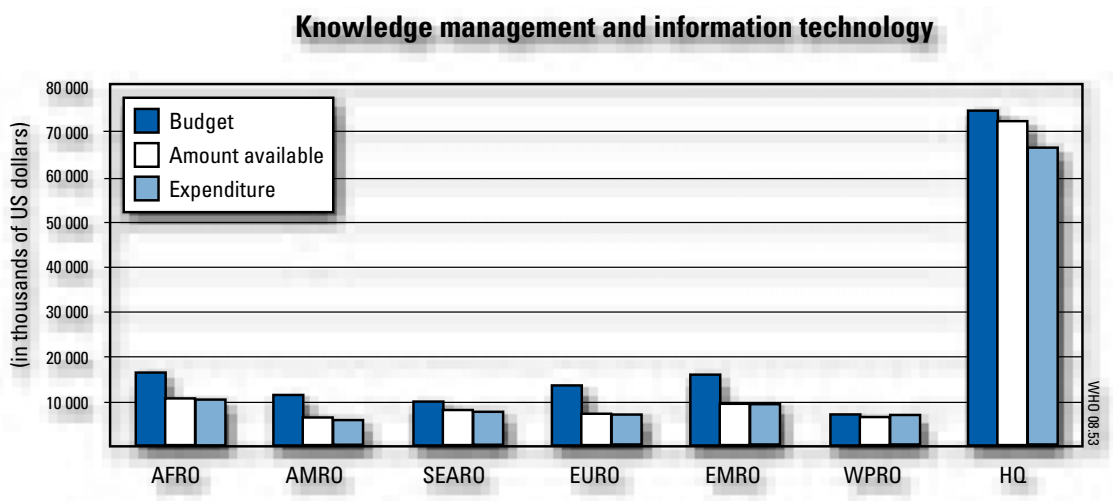
- The coordination and team work demonstrated by those working on the global management system needs to be sustained.
- Adequate financial resources and staffing levels need to be planned for and promoted well in advance of when they are required.
- Good coordination and communication between and within offices enhances project success.

Required actions:

- Implementation of the global management system across the regions requires strong governance.
- Adequate financial resources and a comprehensive, well managed infrastructure encompassing information technology, work tools and methods, need to be in place from the beginning of a biennium. Preparation, especially staff training, is required to implement and run the global management system.
- Efficient planning, monitoring and review processes are needed to ensure that WHO publications are of a high quality.
- Awareness and uptake of WHO support activities and collaboration within the Organization and globally should be encouraged through communication and marketing activities.

FINANCIAL IMPLEMENTATION

Knowledge management and information technology												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	5 753	10 147	15 900	5 318	5 208	10 527	66.2%	5 319	5 183	10 502	99.8%	66.1%
AMRO	4 700	6 193	10 893	5 705	104	5 810	53.3%	5 632	103	5 735	98.7%	52.6%
SEARO	651	8 949	9 600	3 550	4 402	7 952	82.8%	3 550	4 352	7 902	99.4%	82.3%
EURO	4 028	9 272	13 300	3 937	2 919	6 856	51.5%	3 937	2 896	6 833	99.7%	51.4%
EMRO	4 957	10 630	15 587	4 919	4 297	9 215	59.1%	4 918	4 120	9 038	98.1%	58.0%
WPRO	2 617	4 133	6 750	2 741	3 825	6 567	97.3%	2 741	3 806	6 547	99.7%	97.0%
Sub-total Regions	**22 706**	**49 324**	**72 030**	**26 170**	**20 756**	**46 926**	**65.1%**	**26 097**	**20 460**	**46 557**	**99.2%**	**64.6%**
HQ	34 613	39 537	74 150	33 237	38 764	72 001	97.1%	33 222	32 770	65 992	91.7%	89.0%
Total	**57 319**	**88 861**	**146 180**	**59 407**	**59 519**	**118 927**	**81.4%**	**59 319**	**53 230**	**112 549**	**94.6%**	**77.0%**



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Budget and financial management (FNS)

WHO objective(s)

To follow best practice in budget and financial management coupled with integrity and transparency, providing effective and efficient support for budget and financial administration across the Organization for all sources of funds, including relevant financial reporting at all levels, both internally and externally.

Indicator(s) and achievement

- *Timely financial information and accessible analytical tools that allow managers at all levels of the Organization to make well-informed decisions on planning and operational matters*. Monthly financial accounting reports are produced, in which regional and country office expenditures are consolidated. Weaknesses persist in the timeliness with which some expenditure is reported, notably delays in some WHO Representatives' offices in incorporating field-based expenditure. These delays will be addressed when the new global management system becomes fully operational by the end of 2009. Analytical reporting, which allows managers to make well-informed decisions on operational matters, requires tightening up: some offices have established good mechanisms for analytical reporting, others continue to have difficulties. Improved analytical reporting is needed to facilitate the movement of funds within the Organization, and to disaggregate between different types of funds.
- *Budget presentation, implementation and monitoring, enabling Member States and other donors to judge financial performance*. Progress has been made in improving budget monitoring, notably the management of voluntary and regular budget funds has been better integrated; donor reporting deadlines are now respected; budget implementation tables are presented to Member States in accordance with statutory deadlines; and new income and expenditure accounting policies have been implemented in anticipation of the introduction of the new International Public Sector Accounting Standards, thereby enabling better matching of results and expenditure on achieving those results.
- *Acceptance by governing bodies of the biennial financial report, audited financial statements (including an unqualified audit opinion) and the interim financial report and statements*. On target to submit the 2006–2007 Financial Report on time to the Sixty-first World Health Assembly, and also to obtain an unqualified audit opinion.
- *Response to internal and external audit report recommendations, leading to enhanced accountability and supporting appropriate internal control*. Good progress has been made in implementing external and internal audit recommendations, particularly in regional and country offices. A total of 31 internal and 26 external audit reports have been issued. However, the recommendations contained in 19 internal audit reports and 10 external reports remain to be fully implemented. Training for WHO Representatives and Liaison Officers has been encouraged by several regional offices to improve the accountability of country offices for budget and financial management matters. Some recommendations remain outstanding, notably implementation of a risk management framework to better systematically identify and mitigate risks within general management areas of responsibility.

Main achievements

- Progress has been made in preparing for the introduction of the new budget and financial management and accounting systems, which will significantly improve the timeliness and quality of financial and analytical reporting.
- All statutory reporting deadlines have been respected.

- There has been a satisfactory level of compliance with internal and external audit recommendations and in maintaining adequate internal controls.
- Progress has been made in implementing the new International Public Sector Accounting Standards, including by means of changed business procedures and training.
- Investments have performed well producing record interest earnings.
- Nevertheless, there is room for improvement in integrated, timely expenditure reporting, and in budget implementation analysis and support.

Achievement of Organization-wide expected results

Policies and guidance prepared for implementation of new, streamlined functions under delegated authority to countries and regions in line with implementation of the new global management system

Indicator	Baseline	Target	Achievement
Comprehension and implementation throughout the Organization of policies underpinning the global management system	Updated WHO Manual and related procedures and appropriate training programme	Revised policy and procedures fully reflected in the WHO Manual and training programme carried out at all levels	Policy and procedure development and dissemination for global management system is in preparation; some WHO Manual updates remain outstanding

Partly achieved. Some parts of the WHO Manual still require updating. The preparation of training material for the new global management system, which underlies the revision of the Manual, has been completed. The Financial Regulations, Rules and procedures have been updated in readiness for the introduction of the global management system, and extensive briefings in the new procedures provided. The baseline shown above is incorrect: the WHO Manual had not been fully updated at the beginning of 2006.

Integrated budget estimates drawn up, including financing strategies; income and expenditure projections, monitoring and reporting carried out for all sources of funds on a fully integrated basis

Indicator	Baseline	Target	Achievement
Timely and relevant submission of budget estimates to governing bodies	Compliance with Financial Regulations	Compliance with Financial Regulations	Full compliance with Financial Regulations
Timely reporting to satisfy needs of internal management and requirements of Member States	Global consolidated database updated by 18th working day each month; ad hoc reports on financial implementation	Global consolidated database updated by 10th working days each month; monthly reporting by 15th working day	10th working day target not always met because of minor delays in some regional offices. 15th working day reporting deadline was met for most months

Partly achieved. Some difficulties were experienced in meeting the tenth day deadline for consolidating monthly financial information because of human and financial capacity constraints in some budget and finance units. Expenditure updates from country offices have sometimes been delayed owing to system weaknesses, which will be addressed once the global management system is fully implemented. Financial constraints are caused by inadequate budget and financial support in some locations, while human constraints result from unfilled posts or inadequate staff training.

Statutory and other financial reports prepared and submitted to the Health Assembly in accordance with WHO Financial Regulations and Financial Rules, policies and procedures

Indicator	Baseline	Target	Achievement
Submission of interim financial report for biennium 2006-2007 to External Auditors by 31 March 2007	Interim financial report finalized by 31 March	Interim financial report finalized by 28 February 2007	Target not achieved because of organizational changes and human resource constraints at headquarters. Baseline was maintained
Submission of final financial report for biennium 2006-2007 to External Auditors by 31 March 2008	Final financial report finalized by 31 March	Final financial report finalized by 28 February 2008	Impossible to say if this target will be met
External audit opinion and recommendations	Unqualified audit opinion	Unqualified audit opinion	Still awaiting finalization of external audit

Partly achieved. The target of accelerating financial closure has not been met owing to the additional work involved in processing global management system data, as well as some internal reorganization of the budget and financial functions in headquarters, notably the creation of a headquarters service centre, the Headquarters-wide strategic direction and competency review process and subsequent compendium, and global service centre preparations.

Financing strategy for integrated budget management (income and accounts receivable) drawn up and effectively implemented

Indicator	Baseline	Target	Achievement
Timely recording of income	Income recorded within 5 days	Income recorded within 2 days	Not achieved
Accuracy of income database	Chart of accounts aligned with programme budget	Chart of accounts aligned with programme budget	Achieved
Level and timeliness of collection of receivables for all sources of funds	Actual rate of collection 2004–2005	Improved rate of collection compared with 2004–2005	Improvement in the collection of assessed contributions compared to 2004–2005; overall collection rate for the biennium was 95% (2004–2005: 94%)

Partly achieved. Delays in income recording were due to staffing constraints coupled with the extra work created by additional partnership activities and an increase in earmarked voluntary contributions. Reorganization of income recording, coupled with new global management system integrated processes, will lead to better reporting in 2008–2009.

Expenditure and accounts payable managed in order to implement the integrated programme budget

Indicator	Baseline	Target	Achievement
Accuracy of expenditure database	Chart of accounts aligned with programme budget	Chart of accounts aligned with programme budget	Achieved
Timely payment of suppliers and contractors according to contract terms	Payment within 10 days of receipt of payment instruction	Payment on due date of contract	Achieved

Fully achieved.

Funds of the Organization invested and foreign exchange risks managed within acceptable liquidity and risk parameters in order to maintain the necessary level of liquidity and maximize investment potential

Indicator	Baseline	Target	Achievement
Level of investment earnings as compared to accepted benchmarks	Actual performance 2004–2005 compared to benchmark investment percentage	Out performance of benchmark investment percentage by 0.25%	Achieved
Efficiency of banking and payment operations	Level of bank charges for 2004–2005	No increase in level of bank charges	Achieved
Execution of hedging operations within budget appropriated by the Health Assembly	Rate of protection achieved for 2004–2005 within budget appropriation	Full exchange-rate protection achieved within budget appropriation	Achieved slightly better protection of certain currency exposures than in budget assumption for 2006–2007. Hedging gains of $7.8 million

Fully achieved. All targets were fully met as a result of: record investment earnings from a diversified investment portfolio; excellent long-term investment performance by the Staff Health Insurance Fund; and a foreign currency hedging programme which compensated for the depreciation in the United States dollar during 2006–2007.

Lessons learnt and actions required to improve performance

Lessons learnt:

- It is necessary to ensure that resources are allocated through strict budgeting and planning operations in order to meet the objectives.
- Financial constraints have resulted in a shortage of budget and finance staff and unfilled posts in some locations. Uncertainties about financing at headquarters have led to the hiring of short-term staff, which is less efficient than filling positions permanently.

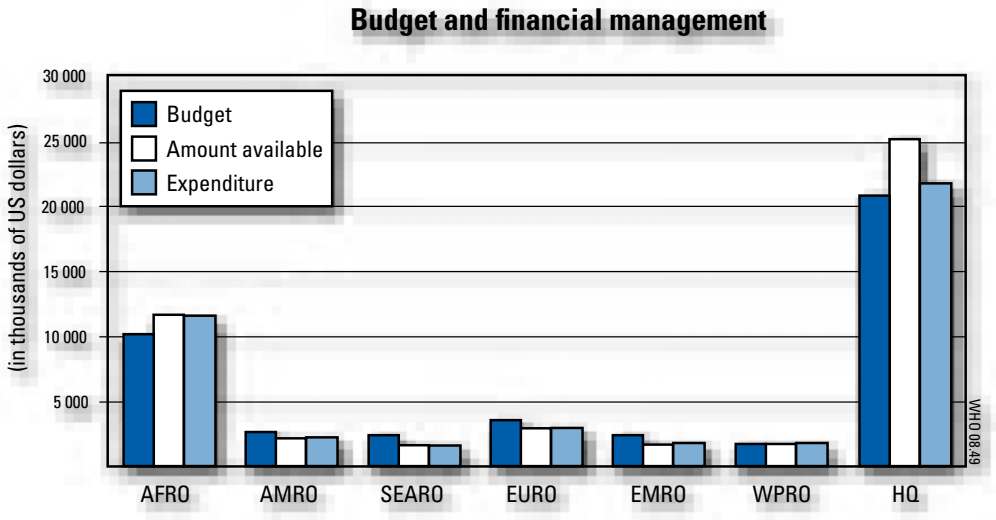
- Support for technical units needs to be enhanced to promote a better understanding of the available resources, expenditure and the status of financial implementation.

Required action:

- To improve needs-based analysis of the resources required and provide adequate sustainable financing in order to achieve results.
- To improve the quality of implementational analysis and reporting for better managing cash flows.
- To exercise vigilance in order to eliminate, in a timely fashion, internal control weaknesses as identified in the internal and external audit reports.
- To ensure the successful completion of global management system preparations, in particular data conversion and testing and training in order to achieve better financial reporting and analysis.

Financial implementation

Budget and financial management												
	Budget			Amount Available *				Expenditure				
	Regular Budget	Voluntary Contributions	Total	Regular Budget	Voluntary Contributions	Total	% of Budget	Regular Budget	Voluntary Contributions	Total	% of Amount Available	% of Budget
AFRO	3 372	6 686	10 058	3 740	8 010	11 750	116.8%	3 740	7 834	11 574	98.5%	115.1%
AMRO	1 888	612	2 500	1 518	605	2 123	84.9%	1 510	605	2 115	99.6%	84.6%
SEARO	873	1 332	2 205	916	617	1 534	69.6%	916	617	1 533	100.0%	69.5%
EURO	2 785	645	3 430	2 384	552	2 936	85.6%	2 384	552	2 936	100.0%	85.6%
EMRO	1 158	1 138	2 296	1 223	454	1 677	73.0%	1 223	454	1 677	100.0%	73.0%
WPRO	1 082	544	1 626	893	830	1 723	106.0%	893	830	1 723	100.0%	106.0%
Sub-total Regions	**11 158**	**10 957**	**22 115**	**10 675**	**11 068**	**21 743**	**98.3%**	**10 666**	**10 892**	**21 558**	**99.1%**	**97.5%**
HQ	10 669	10 093	20 762	9 773	15 263	25 036	120.6%	9 773	11 878	21 651	86.5%	104.3%
Total	**21 827**	**21 050**	**42 877**	**20 448**	**26 331**	**46 779**	**109.1%**	**20 439**	**22 770**	**43 209**	**92.4%**	**100.8%**



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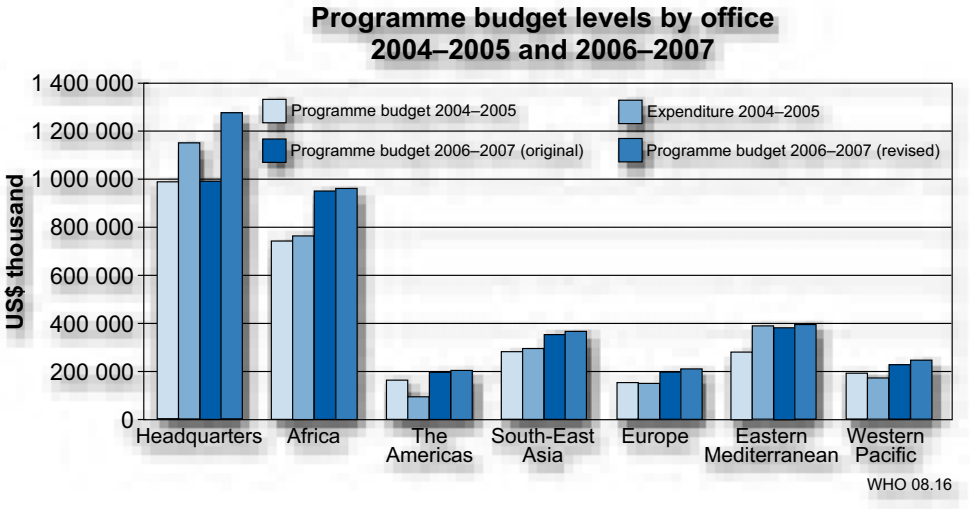
III FINANCIAL IMPLEMENTATION

Overview

The original figure of US$ 3313 million for the Programme budget 2006–2007 grew to US$ 3670 million during the biennium. The latter figure represents a 30% increase over the Programme budget 2004–2005. New demands were placed on WHO and new financing mechanisms were made available to support implementation of approved priorities at a higher level than that originally planned in the Programme budget 2006–2007.

The growth in the Programme budget 2006–2007 was largely the result of increased budget allocations for the following: the Stop TB Partnership's Global Drug Facility, activities related to avian influenza, additional work on vaccines and immunization concerning the GAVI Alliance, prequalification of medicines, human resources for health and patient safety. Activities in these areas are mainly implemented through headquarters; it is for this reason that the greatest increase in the budget was attributed at headquarters, with smaller increases recorded at regional and national levels.



The programme expenditure in the biennium 2006–2007 equalled US$ 3098 million, representing 93.5% of the original amount covered by the Programme budget 2006–2007 and 84.4% of the revised programme budget figures for the same period.

	2006-2007	2004-2005	Percentage increase from 2004-2005 to 2006-2007
	US$ million		
Programme budget (revised) (original level US$ 3313 million)	3670	2824	30.0
Available resources	4257	2984	42.7
Programme expenditure	3098	2729	13.5

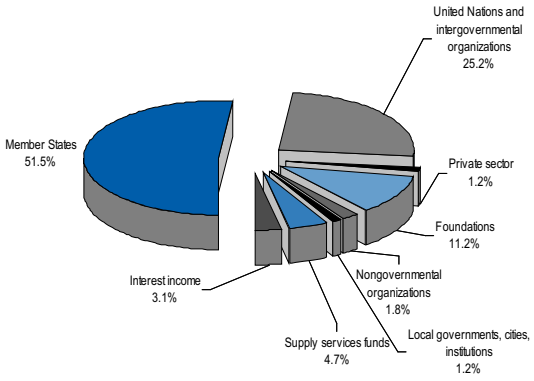
Income

The regular budget represented only 21% of actual income, compared with 29% in the biennium 2004–2005, reflecting the continuing trend towards greater reliance on voluntary contributions to finance the Organization's work. These voluntary contributions were, to a large extent, earmarked and unevenly apportioned between programmes and major offices. A significant proportion of this financing was also contributed for partnerships and collaborative arrangements over which WHO does not exercise full control.

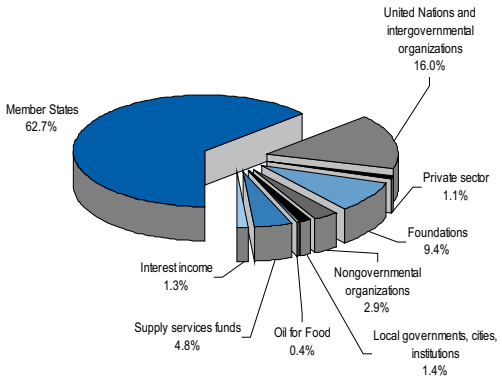
The earmarking of much of the funding provided to the Organization represented another major constraint. Although a move to more flexible funding on the part of certain donors succeeded in raising the absolute level of such funding available, as a proportion of total voluntary contributions, this did not increase over the amount received in the biennium 2004-2005. As a result, the alignment between funding and programme budget requirements in the biennium 2006-2007 was largely unchanged against the preceding biennium. In order to overcome this difficulty, the Organization is continuing its dialogue with donors to increase the proportion of predictable and flexible funding as of the biennium 2008-2009.

The pattern of income reliance also changed between the biennium 2004-2005 and the biennium 2006-2007. The Organization continues to be dependent on contributions from Member States more than any other single type of source, but the extent of that reliance has decreased as a result of increased support from the United Nations and from intergovernmental organizations (notably the European Commission and the World Bank), as well as from private foundations (including the Bill & Melinda Gates Foundation). However, Member States have continued to provide more than half of all voluntary contributions, of which the vast majority involve highly specified support. It is important to note that to date only a limited number of Member States have provided flexible funding. It is hoped that the number will increase in future.

2006–2007

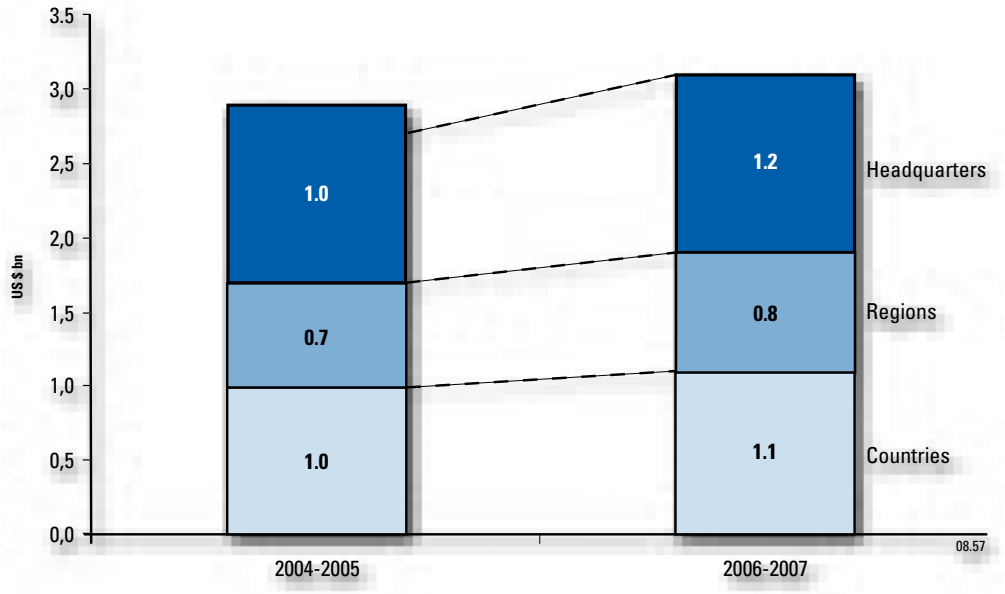


2004–2005



Expenditure and implementation

The biennium 2006-2007 saw a record level of expenditure for programme implementation, which increased by 14% in relation to the biennium 2004–2005, with increases observed at all three levels of the Organization.



However, the expenditure split between headquarters and the regions remained unchanged between the bienniums 2004–2005 and 2006–2007 (headquarters 38%, regions and countries 62%).

Overall analysis of programme budget implementation has to take into account a number of new accounting policies.

- The revised accounting policy, applying a methodology according to which voluntary contributions are recognized upon signature of donor agreements, increased the income recognized in the biennium 2006–2007 by US$ 423.8 million, which had a substantial impact on the amount carried over.
- The application under the new accounting rules of the delivery principle, i.e. that accounting of expenditure will match results achieved, has had a bearing on the level of reported expenditure, making implementation appear lower (the estimated difference for the biennium 2006–2007 is about US$ 125 million). This distorts slightly the comparison of expenditures across bienniums.

Factors influencing the level of budget implementation include difficulties in expanding technical and administrative capacity in step with the growth in demand and income. Scaling up at country level was a particular difficulty, which was exacerbated by a time lag in the deployment of human resources, coupled with delays for administrative reasons in the transfer of funds to regions and countries. It is hoped that efforts made during the course of the biennium 2006-2007 to increase execution capacity – most notably the reform of human resources management, the streamlining of recruitment processes and the introduction of the global management system – will lead to increased rates of implementation from the biennium 2008-2009, especially at country level.

The impact on expenditure is also influenced by donations coming late in the biennium; however, this is a recurring issue and the volume of such donations did not change substantially between the biennium 2004–2005 and the biennium 2006–2007.

During the biennium 2006–2007 the Organization took steps to accelerate balanced implementation across locations and areas of work. An advisory group on financial resources was established with the permanent membership of all Assistant Directors-General and Directors of Programme Management in regional offices. This group, now under the chairmanship of the Deputy Director-General, will play an increasingly important role during the biennium 2008–2009. The group will advise the Director-General on the availability and utilization of resources and the delivery of results against the strategic objectives set in the programme budget. It will oversee the Organization's entire programmatic delivery and provide advice on any steps necessary in order to ensure effective implementation for achieving the Organization-wide expected results set out in the Medium-term strategic plan, and the results expressed in workplans at all levels of the Organization.

The establishment of corporate accounts is essential for supporting the work of the advisory group. During the biennium 2006–2007 these accounts held fully flexible resources or resources whose earmarking simply specified an area of work. Decisions concerning the distribution of resources across major offices were based on dialogue within areas of work, involving headquarters and regional levels. This process was designed to support implementation of the priorities set in the programme budget. Donor support for this initiative was encouraging, with 11 donor Member States contributing sufficiently flexible funds to this income category.

The corporate account mechanism permitted – both internally and externally – a clearer understanding of the complexities and challenges involved in WHO's financing. In view of the interconnections that exist between the different parts of the Organization, the advisory group on financial resources can play an important role in meeting these challenges. Dialogue is continuing with donors so that a robust mechanism can be put in place for increasing the proportion of funds that are less tightly earmarked in future bienniums. Building on the experience of the advisory group and the corporate account mechanism, a core voluntary contribution account has been set up. This is managed in a transparent and accountable manner, ensuring provision of financing in order to close critical funding gaps at headquarters and in the regions. The mechanism for managing this account is intended to provide a high-level overview of the implementation of the programme budget so that interventions can be made to improve specific results as well as the general performance of the Organization.

As can be seen below, six areas of work in the biennium 2006-2007 accounted for just under half WHO's income.

Area of work	Percentage share of programme income	Percentage share of programme budget
Immunization and vaccine development (against poliomyelitis)	17.0	8.3
Immunization and vaccine development (other)	6.1	14.4
Emergency preparedness and response	8.6	3.0
Tuberculosis	6.6	6.3
Epidemic alert and response	6.2	6.2
HIV/AIDS	5.1	7.4
Malaria	2.7	3.7
Others	47.7	50.7
TOTAL	100.0	100.0

Historically, these areas of work have been successful in mobilizing specified resources.

Conversely, a number of smaller areas of work have traditionally faced greater difficulties in raising specified funds and have hence relied more heavily on flexible funds. Consequently, even a small increase in the proportion of flexible funding received by the Organization could lead to major gains in terms of increased alignment of resources with the approved programme budget.

Degree of income flexibility for biennium 2006-2007	Percentage of total voluntary contributions
Fully flexible	1.0
Highly flexible	5.6
Moderately flexible	10.6
Specified	82.8

Funding carried over

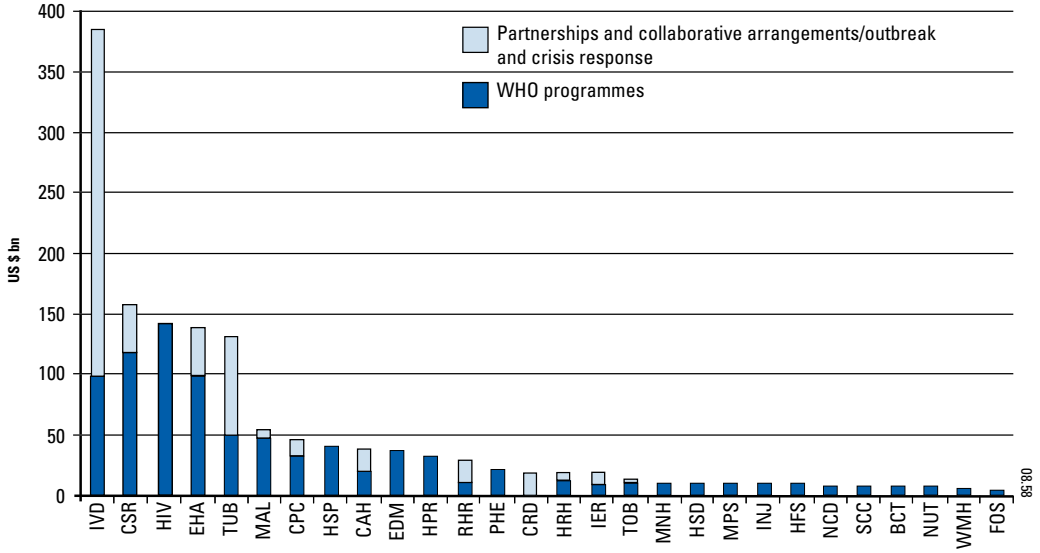
The Organization's increasing dependency on voluntary contributions requires a sizeable amount of funding to be carried over from one biennium to the next in order to ensure continued implementation and avoid programmatic disruption.

Under financial rules, staff costs must be covered for at least six months, although a period of 12 months gives a more reasonable planning horizon in view of the limited predictability of voluntary contributions. Depending on the mix of income from assessed contributions and income from voluntary contributions, and on the proportion of staff to activities within a given programme, a cushion equivalent to between 25% and 40% of the past biennium's expenditure needs to be carried over in order to ensure funding security in respect of voluntary contributions. Programmes with a high staffing component are at the top of this range, a feature typical of programmes with a significant and continuous, normative function.

Any technical area of work carrying over a level of voluntary contributions lower than 25% of its past expenditure level can be considered in trouble, while carrying over more than 40% requires a justification to be provided.

Within the global figure of US$ 1600 million carried over for programme funding, considerable variation could be observed across major offices and technical domains. Some 68% of the total figure concerned specified project funding. Only 57% was for WHO programmes, while 43% concerned partnerships/collaborative arrangements and outbreak/crisis response.

Funding carried over from the biennium 2006-2007 by technical area of work (excluding enabling areas of work)



Although total funding carried over is at a noticeably higher level than has historically been the case, the graph above clearly illustrates that five areas of work account for two thirds of the figure. Of the areas of work concerned, two contain significant elements of partnerships and collaborative arrangements, and two others significant components of outbreak and crisis response.

However, this uneven distribution of funding carried over is, in fact, a further manifestation of the alignment problems that the Organization is working to resolve. If the measures being pursued at present are successful, and if the new global management system succeeds in facilitating easier cash management, it is hoped that the funding carried over will be more equitably distributed enabling programmes to ensure uninterrupted delivery of their programme budget commitments.

TABLES

Table 1. Budget and expenditure summary

Regular budget by organizational level and total voluntary contributions

Financial period 2006–2007

(in thousands of US dollars)

	Programme budget 2006-2007	Transferts effected and unallocated balances	Working a/ budget as at 31 December 2007	Expenditure 2006-2007	Implementation c/ rate as % of working budget
Regular budget					
Country	355 021	(12 700)	342 321	337 194	*98.5*
Regional	246 257	63	246 320	245 222	*99.6*
Global (Headquarters)	278 528	3 060	281 588	280 932	*99.8*
Sub-total	879 806	(9 577)	870 229	863 348	*99.2*
Miscellaneous	35 509	(231)	35 278	35 278	*100.0*
Total regular budget	915 315	(9 808)	905 507	898 626	*99.2*
Voluntary contributions	2 754 846 b/		2 754 846	2 372 488	*86.1*
Total	3 670 161	(9 808)	3 660 353	3 271 114	*89.4*
Less:					
Eliminations - WHO programme activities Statement I Annex 2 (excl. Programme support costs US$ 152 091 thousands)				172 850	
Total - WHO Programme activities Statement I	3 670 161			3 098 264	*84.4*

a/ The Working budget represents part of the Programme Budget that has been allocated and adjusted by transfers between Appropriation Sections and/or Offices.
b/ Other sources figure as noted in EB120/3 (Document EBPBAC 5/5)
c/ The implementation rate is based on the Working Budget as shown in this Table, whereas Tables 2, 3 and 4 show the implementation rate based on the Programme Budget approved by WHA 58.4 and as noted in EB120/3 (Document EBPBAC 5/5).

Table 2. Budget and expenditure summary by area of work – all offices

Financial period 2006–2007 (in thousands of US dollars)

Area of work	Regular budget Programme Budget	Regular budget Programme Expenditure	%	Voluntary contributions Programme Budget	Voluntary contributions Programme Expenditure	%	Total financing Programme Budget	Total financing Programme Expenditure	%
Communicable disease prevention and control	20 059	24 112		132 924	79 060		152 983	103 172	67.4
Communicable disease research	3 757	3 375		104 700	73 852		108 457	77 227	71.2
Epidemic alert and response	47 925	41 439		182 594	101 428		230 519	142 867	62.0
Malaria	15 085	15 905		122 424	154 795		137 509	170 700	124.1
Tuberculosis	11 836	10 600		222 690	174 927		234 526	185 527	79.1
HIV/AIDS	16 148	14 474		258 745	138 694		274 893	153 168	55.7
Surveillance, prevention and management of chronic, noncommunicable diseases	30 728	25 951		33 375	13 437		64 103	39 388	61.4
Health promotion	14 577	17 488		38 070	15 855		52 647	33 343	63.3
Mental health and substance abuse	12 772	10 738		19 492	10 004		32 264	20 742	64.3
Tobacco	13 856	10 870		26 214	16 036		40 070	26 906	67.1
Nutrition	9 431	7 787		17 077	10 850		26 508	18 637	70.3
Health and environment	36 799	33 997		53 613	32 010		90 412	66 007	73.0
Food safety	8 390	9 114		17 627	7 814		26 017	16 928	65.1
Violence, injuries and disabilities	4 973	4 724		17 628	10 332		22 601	15 056	66.6
Reproductive health	8 074	8 697		68 498	52 525		76 572	61 222	80.0
Making pregnancy safer	24 857	17 068		40 294	17 621		65 151	34 689	53.2
Gender, women and health	4 373	3 172		13 330	5 224		17 703	8 396	47.4
Child and adolescent health	27 453	17 576		75 004	40 333		102 457	57 909	56.5
Immunization and vaccine development	14 371	17 089		512 369	636 490		526 740	653 579	124.1
Essential medicines	17 029	18 807		53 839	43 592		70 868	62 399	88.0
Essential health technologies	12 139	11 637		16 547	12 177		28 686	23 814	83.0
Policy-making for health in development	16 160	14 825		29 203	14 807		45 363	29 632	65.3
Health system policies and service delivery	43 302	50 869		88 365	35 564		131 667	86 433	65.6
Human resources for health	38 987	39 663		52 661	18 715		91 648	58 378	63.7
Health financing and social protection	16 145	12 436		28 822	6 640		44 967	19 076	42.4
Health information, evidence and research policy	21 151	20 812		69 255	36 744		90 406	57 556	63.7
Emergency preparedness and response	9 035	10 666		100 402	271 354		109 437	282 020	257.7
WHO's core presence in countries	128 624	135 052		61 979	31 758		190 603	166 810	87.5
Knowledge management and information technology	57 319	59 319		88 861	53 230		146 180	112 549	77.0
Planning, resource coordination and oversight	12 213	13 956		13 479	7 910		25 692	21 866	85.1
Human resources management in WHO	22 384	21 444		29 489	34 386		51 873	55 830	107.6
Budget and financial management	21 827	20 439		21 050	22 770		42 877	43 209	100.8
Infrastructure and logistics	68 524	66 309		61 259	101 338		129 783	167 647	129.2
Governing bodies	24 933	26 810		10 446	8 113		35 379	34 923	98.7
External relations	17 783	15 619		15 043	11 061		32 826	26 680	81.3
Direction	26 787	30 509		11 417	15 170		38 204	45 679	119.6
Substantive areas of work - total	879 806	863 348		2 708 785	2 316 616		3 588 591	3 179 964	88.6
Miscellaneous									
Exchange rate hedging	15 000	14 775		5 000	1 825		20 000	16 600	
Real Estate Fund	7 509	7 396		6 061	409		13 570	7 805	a/
Information Technology Fund	10 000	9 850		15 000	27 188		25 000	37 038	a/
Security Fund	3 000	3 257		20 000	26 450		23 000	29 707	a/
Miscellaneous - total	35 509	35 278		46 061	55 872		81 570	91 150	
Total - ALL OFFICES	915 315	898 626	98.2	2 754 846	2 372 488	86.1	3 670 161	3 271 114	89.1

Table 3. Organization-wide expected results fully achieved, partly achieved, abandoned, deferred or with insufficient evidence to determine extent of achievement – by area of work

Acronym	Area of work	Organization-wide expected results fully achieved	Organization-wide expected results partly achieved	Organization-wide expected results abandoned, deferred, or insufficient evidence to determine extent of achievement	Totals
Essential health interventions					
CPC	Communicable disease prevention and control	3	2	0	5
CSR	Epidemic alert and response	5	0	0	5
MAL	Malaria	0	5	0	5
TUB	Tuberculosis	2	5	0	7
HIV	HIV/AIDS	3	4	0	7
NCD	Surveillance, prevention and management of chronic, noncommunicable diseases	5	0	0	5
MNH	Mental health and substance abuse	4	1	0	5
RHR	Reproductive health	5	1	0	6
MPS	Making pregnancy safer	2	2	0	4
CAH	Child and adolescent health	3	1	0	4
IVB	Immunization and vaccine development	4	3	0	7
EHA	Emergency preparedness and response	3	1	0	4
Health policies, systems and products					
HSP	Health system policies and service delivery	2	1	2	5
HFS	Health financing and social protection	4	0	0	4
IER	Health information, evidence and research policy	3	2	0	5
HRH	Human resources for health	1	1	5	7

Acronym	Area of work	Organization-wide expected results fully achieved	Organization-wide expected results partly achieved	Organization-wide expected results abandoned, deferred, or insufficient evidence to determine extent of achievement	Totals
HSD	Policy-making for health in development	1	5	1	7
EDM	Essential medicines	5	2	0	7
BCT	Essential health technologies	3	2	0	5
Determinants of health					
FOS	Food safety	3	2	0	5
GWH	Gender, women and health	2	3	0	5
PHE	Health and environment	3	0	0	3
HPR	Health promotion	4	2	0	6
NUT	Nutrition	5	1	0	6
TOB	Tobacco	6	0	0	6
INJ	Violence, injuries and disabilities	7	0	0	7
CRD	Communicable disease research	4	2	0	6
Effective support for Member States					
DIR	Direction	5	0	0	5
GBS	Governing bodies	1	3	0	4
REC	External relations	3	4	0	7
BMR	Planning, resource coordination and oversight	2	3	2	7
ILS	Infrastructure and logistics	2	4	0	6
SCC	WHO's core presence in countries	2	2	0	4
HRS	Human resources management in WHO	1	4	1	6
KMI	Knowledge management and information technology	1	7	0	8
FNS	Budget and financial management	2	4	0	6
Totals		**111**	**79**	**11**	**201**

ANNEX 1

SIXTY-FIRST WORLD HEALTH ASSEMBLY
Provisional agenda item 14.1

A61/21
16 May 2008

Programme budget 2006–2007: performance assessment

First report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-first World Health Assembly

1. The eighth meeting of the Programme, Budget and Administration Committee was held in Geneva on 15 and 16 May 2008 under the chairmanship of Professor J. Pereira Miguel (Portugal). The list of participants is annexed.

2. The Committee adopted its agenda.[1]

3. The Committee was briefed on the Secretariat's performance in respect of the Programme budget 2006–2007, including both financial and programmatic implementation. A summary of the forthcoming performance assessment report,[2] together with the Financial report and audited financial statements for the period 1 January 2006 – 31 December 2007,[3] had previously been issued.

4. The following subjects were discussed in some detail: (1) historical trends in relation to income, expenditure, the ratio of assessed contributions to voluntary contributions, and the degree of alignment of income and programme budget figures; (2) measures taken to adapt to the new budgetary environment, in which there was an increasing reliance on earmarked voluntary contributions; (3) factors contributing to the substantial financial carry-over from the biennium 2006–2007 to the biennium 2008–2009; (4) the process for preparing the performance assessment report for the Programme budget 2006–2007, including an overview of its main purpose, the methodology and timeline for the process, and the main findings of the report.

5. It was noted that, although overall expenditure in biennium 2006–2007 was only marginally below the level of the original approved programme budget, financial implementation rates continued to vary between different areas of work. The main factors contributing to the underfunding of some areas and the relatively high level of carry-over in others included the unpredictable timing of receipt of funds; the specificity of the earmarking of the bulk of voluntary contributions; the high proportion of voluntary contributions for partnerships and other collaborative arrangements hosted by WHO; and changes in policies for recording income and expenditure. The Secretariat stressed that, although all

[1] Document EBPBAC8/1.

[2] Document A61/19.

[3] Documents A61/20 and A61/20 Add.1.

voluntary contributions that assist in implementing the approved programme budget were both crucial and very welcome, the relative scarcity of flexible resources and the diminishing proportion of assessed contributions posed significant challenges to ensuring full implementation of the programme budget.

6. The Committee welcomed the summary of the performance assessment report for the Programme budget 2006–2007 and looked forward to reviewing the full version, revised in the light of the Committee's comments. The full version would be discussed at regional committee meetings and considered by the Executive Board at its 124th session.

7. The Committee underlined the importance of the performance assessment findings for informing decisions about reprogramming and the preparation of the Programme budget 2010–2011. The Committee also stressed the importance of the programme budget assessment process as an integral part of WHO's results-based management framework, and its role in helping donors to move towards more flexibility in their voluntary contributions.

8. The Committee commented on the time constraints for preparing both the summary and full performance assessment reports, but stressed the importance of the timely receipt of both. The full assessment findings were needed in order to inform discussions concerning the Programme budget 2010–2011. Some members of the Committee regretted that the established timeline for discussions would deny Member States the opportunity to discuss the full assessment report before the governing bodies' discussion of future proposed programme budgets. It was suggested that the Secretariat submit proposals for rectifying the situation to a subsequent session of the Committee.

The Committee, on behalf of the Executive Board, recommended that the Health Assembly note the report contained in document A61/19.

ANNEX

LIST OF PARTICIPANTS

MEMBERS AND ALTERNATES

Portugal

Professor J. Pereira Miguel (Chairman)

Liberia

Dr W.T. Gwenigale (Vice-Chairman)

Afghanistan

Mr O. K. Noori (Alternate to Dr H. Ahmadzai)

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Dr A. Somantri (Alternate)
Dr T.W. Putri (Alternate)
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Mrs M.A. Jaquez (Alternate)
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Mrs M. Mallikaratchy (Alternate)

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Ms A. Chick (Alternate)

Ex officio member

Singapore

Dr B. Sadasivan (Chairman of the Executive Board)

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Mr E.H. Elbey (Algeria)
Ms C Patterson (Australia)
Ms R. Enn (Austria)
Dr F. Helmut (Austria)
Mr C. Wurzer (Austria)
Mr D. MacPhee (Canada)
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Mr N. Plattner (Switzerland)
Mrs P. Kanchanahattakij (Thailand)
Ms C. Kitsell (United Kingdom of Great Britain and Northern Ireland)

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ANNEX 2

Summary of the recommendations of the Quality Assurance Committee

The Secretariat decided to carry out a quality review of the reports for the Programme budget 2006-2007 performance assessment prepared by focal points for the 36 areas of work. A quality assurance committee, including two external evaluators, was established for this purpose.

Under its terms of reference the Quality Assurance Committee was to review the reports for all 36 areas of work, identify omissions, inconsistencies and factual errors; and review completeness, quality and evidence for indicator values in efforts to ensure accuracy. The Committee was also requested to provide a final report with recommendations for improvement of the reporting process and related products.

The Quality Assurance Committee found that the performance assessment reports were of extremely variable quality. None were outstanding and many were poor. A common problem was that reporting units did not follow the guidelines provided, which resulted in superfluity and lack of consistency across and within reports. More specific problems and recommendations related to indicators and regional reporting are indicated below.

INDICATORS

Many indicators in the Programme budget 2006-2007 are of poor quality. Some are unclear, unspecific, meaningless or irrelevant; others are difficult or impossible to measure, or do not reflect the work of the Secretariat. Baseline values are sometimes missing and related targets are consequently poorly defined. The achievements noted for indicators do not consistently refer to the indicator concerned or do not refer specifically to the Secretariat's achievements. The Medium-term strategic plan 2008-2013 contains 243 indicators of Organization-wide relevance. Making these indicators meaningful and useful across all levels of the Organization represents a major challenge, especially as an effective institutional overview, or coordination, of indicators is currently lacking. Resolving indicator problems requires various issues to be reconsidered within a broader process than that currently envisaged.

Recommendation

- Efforts should be invested in improving indicators to ensure that they are clearly defined, measurable, specific, meaningful and relevant. The recently completed review of indicators provides an important tool for making improvements in this area.

REGIONAL REPORTS

The regional performance assessment reports, which represented the main source for the Organization-wide reports, are of extremely variable quality. This finding cuts across both regions and areas of work. In fact, one region did not report according to Organization-wide guidelines, taking a different approach altogether.

The Committee found that some regions perceive the regional reporting exercise to be of limited value to them. This highlights the need to better integrate and align regional and Organization-wide assessment processes, and enhance the relevance of the reporting process for regions.

Recommendations

- Means to increase the relevance of the reporting process for regions should be sought through greater alignment and harmonization of reporting procedures and enhancing the regions' understanding of the purpose and context of the reports.
- Responsibility for the preparation of future regional reports should from the outset be clearly defined as lying with strategic objective facilitators.
- The general management cluster should solicit regional views from both planning and technical staff and should compile their suggestions on ways to improve the quality and coordination of the performance assessment reporting system.

World Health Organization

Designed by D. Meisner WHO/GRA