World Health Organization

SIXTY-FIRST WORLD HEALTH ASSEMBLY **A61/19**
Provisional agenda item 14.1 **9 May 2008**

Programme budget 2006–2007: performance assessment

Report by the Secretariat

1. 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.

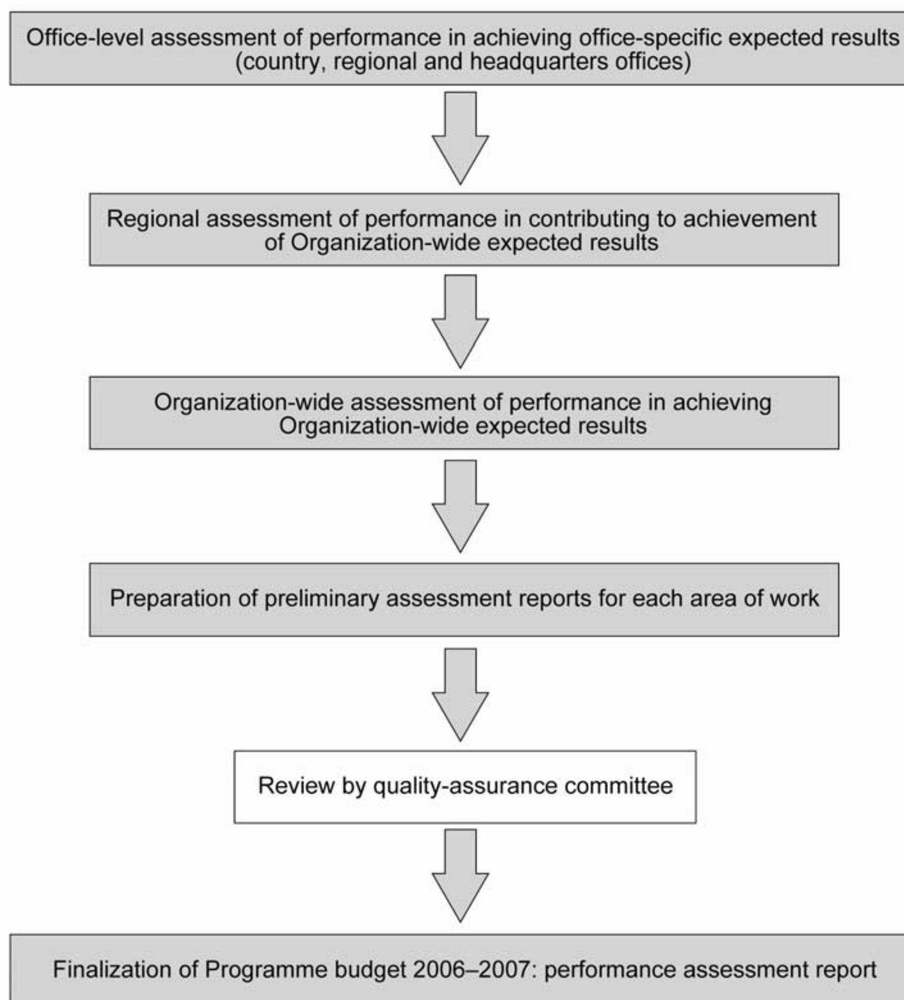
2. The performance assessment forms an integral part of WHO's results-based management framework. The biennial monitoring and assessment processes, of which it is a part, also include periodic workplan monitoring, and the mid-term review of progress towards the achievement of expected results. The importance 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]

3. 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.

4. 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.

5. 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] See document EB122/3.



6. 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.

7. 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.

8. 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.

9. 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.

10. 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.

11. 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.

12. The findings of the Programme budget 2006–2007: performance assessment are summarized below. The full report will be considered by the regional committees later this year and by the Executive Board at its 124th session in January 2009, according to the schedule recommended by the Programme, Budget and Administration Committee to the Executive Board in January 2007.[1]

WHO OBJECTIVES: ACHIEVEMENTS AND CHALLENGES

13. This section provides a summary of the principal achievements recorded, and the challenges met, in efforts to satisfy the objectives set out in the Programme budget 2006–2007.

Infectious diseases

14. Infectious and communicable diseases, especially HIV disease, tuberculosis and malaria, continued to fuel morbidity and mortality, ruin livelihoods and impede development during the biennium. The optimism engendered by reduced incidence rates of tuberculosis and wider implementation of WHO's tuberculosis control strategy (DOTS), with increased case detection and sustained high treatment-success rates, was dampened by the spread of multidrug-resistant disease and the emergence of extensively drug-resistant tuberculosis. Global tuberculosis prevalence rates declined, but at a pace that was unlikely to result in the targeted halving of rates by 2015. Preliminary findings indicate that the incidence of severe and uncomplicated cases of malaria fell in all regions and the proportion of households having at least one insecticide-treated bednet increased globally, particularly in Africa. At the end of 2007, 74 countries had adopted artemisinin-based combination

[1] Document EB120/3.

therapies as their national malaria treatment policy. Nevertheless, there were at least one million deaths per year due to malaria, 82% in children under five years of age. A more robust methodology for estimating the incidence of HIV/AIDS suggested the pandemic has peaked, in part because of preventive efforts and progress in introducing and extending antiretroviral treatment. In total, some 140 countries at the end of the biennium provided comprehensive programmes of HIV prevention and care.

15. By the end of 2007, the efforts of the Global Polio Eradication Initiative had reduced the number of cases of poliomyelitis by 84% compared with 2006, and indigenous transmission of poliovirus had been interrupted in Egypt and Niger and was increasingly geographically restricted in the four remaining endemic countries. Immunization against measles continued to bring important public health benefits. The reduction in the number of measles deaths surpassed original targets, with Africa – the region with the heaviest burden of disease due to measles – leading the way. Although globally coverage with three doses of diphtheria-tetanus-pertussis vaccine increased by only 2% (to 79%), the coverage rate in the WHO African Region increased by 7% to 72%. In a further 12 Member States immunization coverage with three doses of that vaccine reached more than 90%.

16. During the biennium 2006–2007, the threat of an avian influenza pandemic continued, with almost no country that experienced large outbreaks in commercial or backyard flocks succeeding in eliminating the virus from its territory, and with the mortality rate in infected humans remaining high. On 15 June 2007, the International Health Regulations (2005), one of whose aims is to stop events at source before they become an international threat, entered into force. In response to concerns about avian influenza at least 105 countries updated their national strategic plans against zoonotic diseases. In increasing numbers, countries also became capable of contributing significantly to international research on communicable diseases. Capacity for laboratory, clinical and social science research expanded, as did that for training in key institutions in Africa, Asia and Latin America.

17. At least 90 countries had an active national programme in place targeting one or several endemic tropical diseases. More than 75 countries were making progress towards the goals adopted by the Health Assembly of eradicating or eliminating various diseases. Intensified activities in the campaign for eradication of dracunculiasis cut the number of cases from more than 25 200 in 2006 to less than 10 000 at the end of 2007.

Noncommunicable diseases

18. The burden of chronic, noncommunicable diseases is high in all regions, accounting for 60% of all deaths globally, and 80% of deaths in low- and middle-income countries. A reduction in the global burden of blindness and visual impairment was recorded for the first time, and progress was made in documenting deafness and hearing impairment. An increasing number of countries benefited from WHO's technical support to elaborate national policies, plans and programmes for the prevention and control of noncommunicable diseases. Eighty-nine countries had formulated, or were in the process of formulating, policies or prevention programmes to tackle violence and injuries, and 49 countries had formulated policies on disability and implemented plans to strengthen rehabilitation services. During the biennium, the number of health promotion strategies at country level grew rapidly; many of these integrated priority areas and plans for public-health activity such as ageing, youth, the settings approach to health-promotion, oral health, noncommunicable diseases and risk factors. An increasing proportion of countries also took steps to strengthen policies and services for the care of people with mental, neurological and substance-use disorders, including many low- and middle-income countries.

19. One hundred and fifty-one Member States had become Parties to the WHO Framework Convention on Tobacco Control by the end of the biennium, making it one of the most quickly ratified and broadly supported treaties in the history of public health. Sixteen countries had a fairly comprehensive ban on smoking in at least eight places (e.g. hospitals, schools, universities, government offices, indoor workplaces, restaurants, bars, and other indoor public places). An additional 35 countries had complete bans in health-care and educational facilities, as well as in at least three other settings. The proportion constituted by taxes in the price of a pack of cigarettes reached between 50% and 75% in 55 countries, and exceeded 75% in a further four countries. Twenty countries had met the standard set by the Framework Convention for bans on advertisements, and 41 had met the Convention's criteria for health warnings on packets of cigarettes.

20. In the area of nutrition, 101 countries had policies and programmes in place to combat malnutrition, and at least 59 countries showed progress towards achieving the Millennium Development Goal related to nutrition. With regard to efforts in support of food safety, 78% of Member States shared data on foodborne diseases through their participation in the WHO's global surveillance network for *Salmonella*, and 85% of Member States participated in WHO's International Food Safety Authorities Network. In September 2007 more than 50 countries and international organizations attending the High Level International Food Safety Forum (Beijing, 26 and 27 November 2007) adopted the Beijing Declaration on Food Safety, which urges countries to develop comprehensive programmes in order to improve consumer protection.

Health systems

21. There was a marked increase in the number of partnerships, initiatives, funding mechanisms and implementing agencies devoted to public health during the biennium 2006–2007; health was also accorded greater priority on both development and political agendas. By the end of the biennium, 72 countries had adopted new governance approaches to health systems issues and 51 countries were implementing strategies or organizational approaches aimed at strengthening the delivery of health services. Concerted efforts in this area have succeeded in sensitizing many more countries to the importance of ensuring adequate human resources for health; almost all regions have adopted resolutions on regional plans on human resources for health, with most countries reviewing national human resources plans and policies, or producing new ones. Regional observatories for human resources for health were established in the African and Eastern Mediterranean regions, while the network in the Region of the Americas continued to grow.

22. By the end of the biennium at least 132 countries had introduced new, or updated existing, national medicine policies within the preceding 10 years, bringing together all components of the essential medicine programme. At least 88 countries in five regions used basic operational frameworks for the integration of essential health technologies into health systems as part of their national policies on health technology management.

23. In at least 50 countries capacity to produce essential information for policy development was noticeably strengthened, including capacity to produce information on health expenditure flows, and on extent of financial catastrophe and impoverishment linked to out-of-pocket payments for health. A substantial number of countries assessed their health information systems and began to eliminate weaknesses therein. Better data became available on coverage of interventions and countries made greater use of comprehensive data to assess the performance of health systems. However, national capability to report on progress towards achieving Millennium Development Goals 4 and 5 remained insufficient, and there was no evidence of a reduction in the funding gap for health research. In the area of gender, women and health, there was an increase in the proportion of Member States making

use of WHO's tools for integrating gender considerations into the development of health policies, strategies and programmes.

Maternal and child health

24. The proportion of women seen by a skilled attendant at least once during the antenatal period is estimated to have reached 85% during the biennium. There was also a significant increase in the presence of skilled birth attendants at childbirth. In most Asian, European and Middle Eastern countries, almost all women were assisted by skilled health personnel at childbirth. Globally, about 70% of women were assisted by a skilled attendant at childbirth, although the proportion varied between urban/rural and high-income/low-income populations. By the end of the biennium, the tracking of global progress towards achieving Millennium Development Goal 4 (to reduce child mortality) revealed that, of the 68 countries with the highest mortality rates, 16 were on track to meet the Goal; 26 were making progress but needed to accelerate; and 12 had made no progress. Countries in all regions had developed child health strategies, most of which use integrated management of childhood illness as the main platform for reducing child mortality. Coverage of case management was increasing, with 56% of children with suspected pneumonia being taken to an appropriate health provider and 38% of children with diarrhoea receiving oral rehydration and continued feeding. Interventions in support of adolescent health had expanded, their principal objectives being to create adolescent-friendly health services and to reach those adolescents who are most at risk.

Health and environment

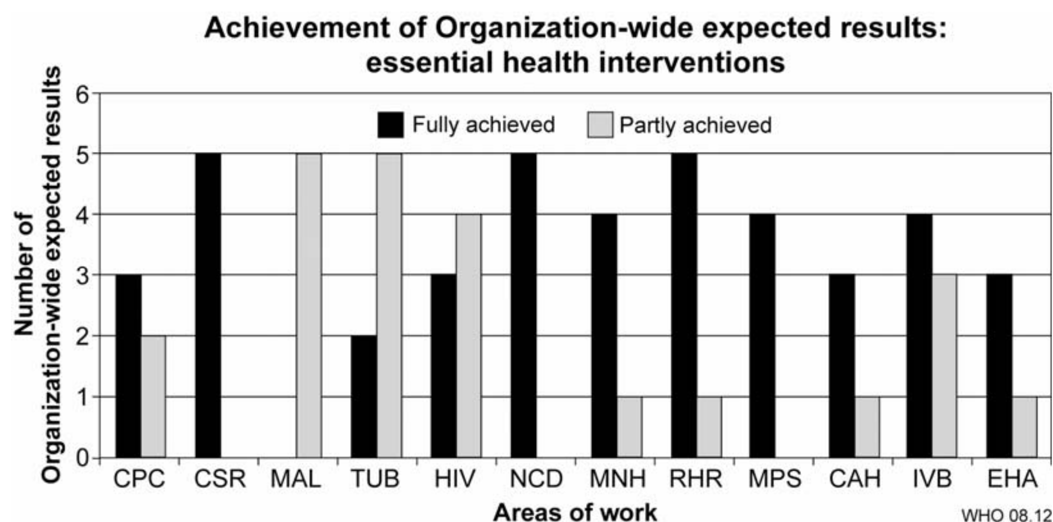
25. Various commitments were made during the biennium to the protection of environment and health at national, regional and international levels. Some of these commitments were broad, such as the Bangkok Declaration on Environment and Health, made at the First Ministerial Regional Forum on Environment and Health (Bangkok, 8–9 August 2007). Other commitments were made on specific issues, such as water and sanitation, and occupational health. The area of climate change and health commanded increased international attention as part of efforts made across the United Nations system to combat global warming.

SECRETARIAT PERFORMANCE IN ACHIEVING ORGANIZATION-WIDE EXPECTED RESULTS

26. 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 these expected results is recorded using the following terms: "Fully achieved" means that all indicator targets for the expected results were met or surpassed; "Partly achieved" means that one or more indicator targets were not met; and "Abandoned, deferred or insufficient evidence" means that changes to original plans resulted in the abandonment of the Organization-wide expected result, that achievement of the expected result was deferred to beyond the biennium 2006–2007, or that insufficient evidence exists to determine the level of achievement.

Essential health interventions

27. Twelve areas of work fall within this group.[1]



28. **Communicable disease prevention and control (CPC).** Work continued during the biennium to consolidate and streamline strategies for the prevention and control of neglected tropical diseases, and evidence suggested that mass preventive chemotherapy could break chains of transmission. Several innovative and cost-effective interventions, techniques and tools were devised and validated in low-resource settings, and access to them increased as foreseen during the biennium. Two Organization-wide expected results in the communicable disease prevention and control area of work were only partly achieved. They relate to the development of guidelines, policies and strategies; and the development of innovative partnerships.

29. **Epidemic alert and response (CSR).** As part of a more comprehensive approach to international health security, the Secretariat provided a mechanism for WHO's alert and response activities in respect of epidemics and other public health emergencies, which operates on a 24 hours a day, 365 days a year basis. In response to the demands of the International Health Regulations (2005), during the biennium provision of support accelerated to other programmes, including those in the areas of chemical safety, radiation protection and food safety. Timely technical support was provided to countries experiencing epidemics of cholera, meningitis, avian influenza, Ebola and Marburg haemorrhagic fevers and yellow fever. All Organization-wide expected results in the epidemic alert and response area of work were fully achieved.

30. **Malaria (MAL).** The Global Malaria Programme was revitalized, and evidence of improved outcomes in malaria control, including reduced mortality, was recorded. However, work to combine "catch up" campaigns with "keep-up" approaches involving routine activities of the Expanded Programme on Immunization and antenatal clinic services, did not advance in most countries.

[1] 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).

Inadequate forecasting and insufficient capacity for procurement and supply-chain management hindered efforts to expand activities and make the transition from chloroquine to artemisinin-based combination therapies for malaria treatment. Home-based management of malaria, and systems for routine surveillance at country level also remained weak in many cases. For these reasons, all five Organization-wide expected results in the malaria area of work were only partly achieved.

31. **Tuberculosis (TUB).** The Stop TB Partnership's Global Plan to Stop TB 2006–2015 and WHO's Stop TB strategy, on which the Plan is based, were launched during the biennium. Coordination between stakeholders in tuberculosis control was improved in most countries; in addition, significant progress was made in work to launch new approaches for expanding access to and effectiveness of tuberculosis control by means of the following: public–private collaboration, collaboration between tuberculosis and HIV programmes, community involvement and social mobilization. The Global TB Drug Facility and the Green Light Committee also expanded their coverage, including in low-resource settings. Five of the seven Organization-wide expected results in the tuberculosis area of work were only partly achieved. These relate to the implementation of a global plan for DOTS expansion; support for implementation of long-term national plans for DOTS expansion and sustained tuberculosis control; the sustaining of political commitment and the mobilization of adequate resources; the maintenance and expansion of surveillance and evaluation systems at national, regional and global levels; and the provision of adequate guidance and support to countries to tackle multidrug-resistant tuberculosis in countries with high HIV prevalence.

32. **HIV/AIDS (HIV).** All regions registered a significant increase in coverage with antiretroviral treatment during the biennium. There was also a marked increase in resources channelled to HIV/AIDS, and support was provided to help countries to access funds. Countries were also provided with support to strengthen the capacity of their health systems to respond to HIV/AIDS and related conditions. In the African Region, the percentage of districts with at least one facility providing HIV testing and counselling increased to about 60% – representing a ten-fold increase compared with the previous biennium. In the Region of the Americas, the Regional Strategic Plan for HIV/AIDS/STI, 2006–2015 – designed to support attainment of the goal of universal access to treatment for HIV/AIDS – was approved by the 46th Directing Council of PAHO.[1] Four Organization-wide expected results in the HIV/AIDS area of work were only partly achieved. These relate to the provision of support to expand treatment and care; the use of normative guidelines and other tools; the strengthening of reporting and surveillance systems; and the provision of support for the uninterrupted supply of HIV-related commodities and medicines.

33. **Surveillance, prevention and management of chronic, noncommunicable diseases (NCD).** Regional strategies and frameworks for surveillance, prevention and management of chronic noncommunicable diseases were developed and endorsed in three regions, and data collection progressed significantly in most regions through surveys using the WHO STEPwise approach to risk factor surveillance. An increasing number of countries made use of WHO's technical support to develop national policies, plans and programmes to prevent and control noncommunicable diseases. All Organization-wide expected results in the surveillance, prevention and management of chronic noncommunicable diseases area of work were fully achieved.

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[1] Resolution CD46.R15.

34. **Mental health and substance abuse (MNH).** The quality and quantity of technical support provided to Member States in the area of mental and neurological disorders and those relating to substance use increased substantially during the biennium. WHO is a global provider of high-quality scientific and research data on the public-health aspects of these disorders, and has assumed a lead role in advocating for protection of sufferers' rights. An assessment was conducted of public-health problems caused by harmful use of alcohol worldwide; a review of public-health evidence of the effectiveness of different policy options was also completed, involving broad consultation with relevant stakeholders. One Organization-wide expected result in the mental health and substance abuse area of work was only partly achieved. This relates to the provision of support to countries for development of evidence-based strategies, programmes and interventions for the prevention and management of mental and neurological disorders.

35. **Reproductive health (RHR).** WHO regional and country offices continued to implement WHO's strategy on reproductive health, which included the development of country plans. A global action plan for WHO's Global Strategy for the Prevention and Control of Sexually Transmitted Infections was also developed in 2007. The WHO/UNFPA Strategic Partnership Programme helped to foster much-needed links between activities for sexual health and those for reproductive health, particularly in the areas of family planning and sexually transmitted infections at country level. One Organization-wide expected result in the reproductive health area of work was only partly achieved. This relates to making new evidence, products and technologies available to improve reproductive and sexual health, and strengthening research capacity.

36. **Making pregnancy safer (MPS).** Efforts to make pregnancy safer benefited from greater awareness, political commitment and funding on the part of both bilateral donors and countries themselves. Joint planning and monitoring were improved, allowing for coordinated policy and strategy development and enhanced technical support to countries. National and institutional capacity for improving maternal and newborn survival and health were also strengthened. All four Organization-wide expected results in the making pregnancy safer area of work were fully achieved during the biennium.

37. **Child and adolescent health (CAH).** Implementation of WHO's strategy for the integrated management of childhood illness expanded significantly in all regions, resulting in increased geographical coverage and a greater focus on pre-service training, hospital care improvement, newborn health, and community-level interventions. In line with the growing awareness of the relative importance of neonatal deaths in overall under-five mortality, activities in support of newborn health increased in all regions and the integrated management of childhood illness was expanded to include the newborn period. Adolescent health activities were also extended at all levels of the Organization, with the principal aim of creating adolescent-friendly health services and reaching the most at-risk adolescents. Efforts in this area benefited from the publication of a study as part of a series on programming for adolescent health,[1] which involved a "Steady, Ready, Go" approach to the assessment of evidence concerning the effectiveness of interventions. One Organization-wide expected result in the child and adolescent health area of work was only partly achieved. This relates to the provision of guidance and technical support and the conducting of research for improving neonatal and child survival, growth and development.

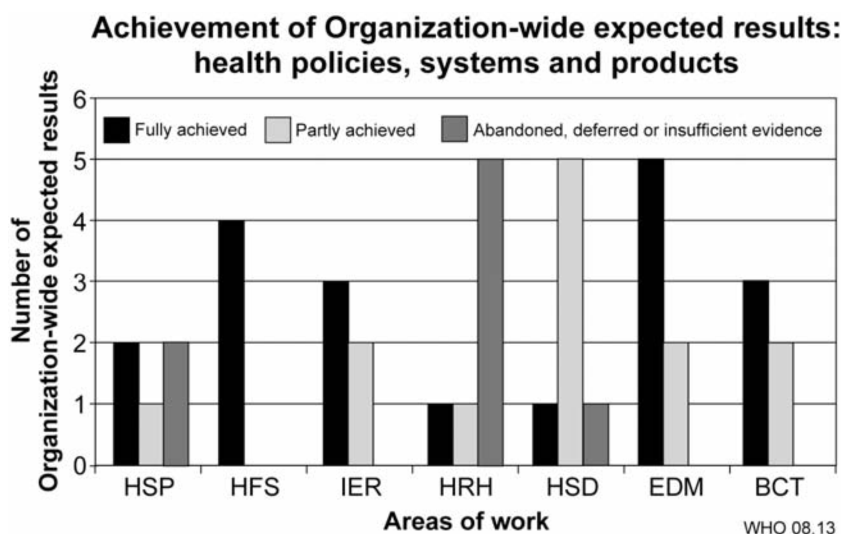
[1] WHO Technical Report Series, No. 938, 2006.

38. **Immunization and vaccine development (IVB).** The Global Immunization Vision and Strategy 2006–2015 was developed and implemented by WHO and UNICEF during the biennium. A set of activities to accelerate the introduction of new vaccines was also initiated in collaboration with the GAVI Alliance. An action plan for new and underutilized vaccines was developed to provide a platform for coordinating related activities in the countries whose need of vaccines is the greatest. Following the launch of the global pandemic influenza action plan to increase vaccine supply, significant progress was recorded in evaluating the most promising strategies, in supporting countries to acquire technology to manufacture influenza vaccine, and in determining priorities for research. Successful results were obtained in research supported by WHO, including research (in partnership with the Program for Appropriate Technology in Health) for a group A meningococcal conjugate vaccine, and research for a measles aerosol vaccine. A research and development strategy was also elaborated for malaria vaccines. Three Organization-wide expected results in the immunization and vaccine development area of work were only partly achieved. These relate to the strengthening of country capacity to implement policies and ensure that immunization programmes use vaccines of assured quality; maximizing access to vaccines and accelerating disease-control efforts; and the provision of effective coordination and support for, inter alia, interrupting the circulation of any reintroduced poliovirus, and achieving certification of global poliomyelitis eradication.

39. **Emergency preparedness and response (EHA).** WHO's work on partnerships for activities in Member States on risk-reduction, preparedness, response and recovery in respect of disasters advanced considerably in all regions. WHO discharged the function of lead agency of the health cluster within the framework of the United Nations humanitarian reform process, convening between 30 and 40 partners from within the United Nations system and beyond. The Organization also participated actively in the different bodies of the Inter-Agency Standing Committee for humanitarian action. Effective interaction with donors progressed and WHO continued to be an active partner in the International Strategy for Disaster Reduction. The standard operating procedures for health emergencies and internal managerial and administrative arrangements were revised, and a new mechanism was put in place for the provision of surge capacity in response to health crises, enabling technical expertise to be mobilized more effectively. Inter-country technical activities for enhancing disaster preparedness and risk reduction and for improving disaster management capacity within the health sector were undertaken in all regional offices. One Organization-wide expected result in the emergency preparedness and response area of work was only partly achieved. This relates to the strengthening of operational presence in countries.

Health policies, systems and products

40. Seven areas of work fall within this group.[1]



41. **Health system policies and service delivery (HSP).** WHO staff worked with government officials in all regions to shape health sector policies, strategies and reforms. In addition to increasing its involvement and influence upstream, WHO made an important contribution to health system strengthening and the way health systems are financed by external agencies. The earmarking of resources by the GAVI Alliance – "the health system strengthening window" – was a significant initiative in this regard: during the biennium 40 proposals were prepared with support from WHO, and about US$ 420 million was made available to countries from this source. WHO's work on patient safety expanded rapidly during the biennium. A framework for guiding work on health systems strengthening – *Everybody's business*[2] – was designed and published and work on health systems strengthening was more closely linked to and integrated with work on specific programmes in order to improve outcomes. One Organization-wide expected result in the health system policies and service delivery area of work was only partly achieved. This relates to the preparation of guidance and the provision of technical support in relation to policy-making, regulation, strategic planning, implementation of reforms and interinstitutional coordination. The extent of achievement of two other Organization-wide expected results could not be determined. The results in question relate to provision of guidance and technical support on improved alignment of population-based public health policies and health service policies; and provision of guidance and technical support on effective integration of health services with disease-specific programmes.

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[1] 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).

[2] *Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action.* Geneva, World Health Organization, 2007.

42. **Health financing and social protection (HFS).** Through policy dialogue, analysis and capacity-building, WHO was able to promote and facilitate national-level policy processes that were consistent with the goal of universal coverage and other objectives for health financing and social protection. WHO also made a substantial contribution to the collation, analysis and dissemination of essential information required by decision-makers, including the sharing of best practices in relation to health financing. Collaboration with internal and external partners in the area of health financing and social protection increased across the Organization. All four Organization-wide expected results in the health financing and social protection area of work were fully achieved.

43. **Health information, evidence and research policy (IER).** Essential health statistics, such as those presented in *World health statistics*, were published in the regions and at headquarters, and a high number of visits to WHO's web site were recorded as a result. Health systems research and health information systems were strengthened at country level, and major analyses of the health situation and trends in the African Region and the Region of the Americas were conducted. Important global analyses were also carried out, including for the global burden of disease, mortality and causes of death. Two Organization-wide expected results in the health information, evidence and research policy area of work were only partly achieved. These relate to the strengthening of national health research for health-systems development; and the determination of guidelines and standards for the ethical conduct of health research and best practices at WHO.

44. **Human resources for health (HRH).** *The world health report 2006*[1] highlighted the worldwide crisis in human resources for health. World Health Day 2006 was dedicated to the health workforce, and in May 2006 the Global Health Workforce Alliance – a global partnership aimed at strengthening advocacy – was launched. These and other advocacy efforts helped to bring the crisis in human resources for health to the top of the international health agenda. A common framework for action to provide a coherent and comprehensive approach to human resource policy analysis and development was elaborated and is now being implemented in a number of countries. One Organization-wide expected result in the human resources for health area of work was only partly achieved. This relates to the strengthening of leadership, policy-making, public health, management and research capacities. The extent of achievement of another five Organization-wide expected results could not be determined because their indicator target values were defined in relation to a baseline survey that was not conducted during the biennium as originally foreseen.

45. **Policy-making for health in development (HSD).** Several important health and development partnerships – including partnerships with United Nations agencies, individual countries, national human rights institutions, national ethics committees and nongovernmental organizations – were established or strengthened. Several normative documents were developed and released during the biennium; these included the final report of the Commission on Social Determinants of Health, fact-sheets on health and human rights, a report on ethical considerations in developing a public health response to pandemic influenza, and a methodological framework for the assessment of trade in health services. Five Organization-wide expected results in the policy-making for health in development area of work were only partly achieved. These relate to the strengthening of country capacity to ensure that plans and strategies support increased investments in health; the engagement of WHO in global dialogues, and in dissemination of best practices and processes of development; the initiation of implementation of WHO's strategy on health and human rights, and the strengthening of capability at regional level to support Member States in integrating a human-rights approach into health-related policies, laws and programmes; building, at country, regional and global levels, the capacity to

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[1] *The world health report 2006: Working together for health*. Geneva, World Health Organization, 2006.

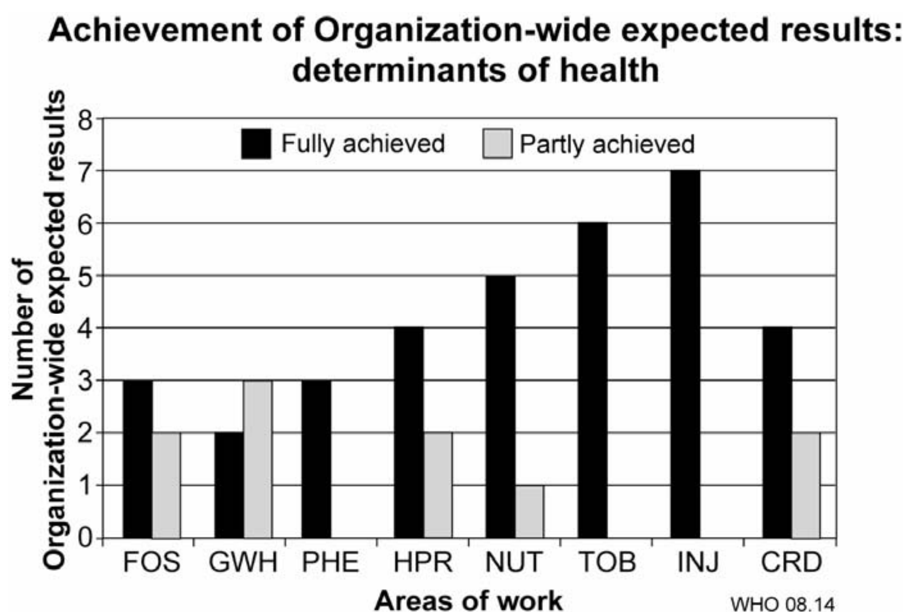
measure, assess and act on cross-border risks to public health; and strengthening the capacity of Member States to formulate and implement legislation and regulations to protect and promote public health. Another Organization-wide expected result, which concerned the endorsement by WHO's governing bodies and adoption by countries of the recommendations of WHO's commission of equity and social determinants of health, was deferred.

46. **Essential medicines (EDM).** The WHO-managed Prequalification Programme for essential medicines and use of the WHO/Health Action International methodology for medicines-pricing surveys were expanded during the biennium. A large number of countries developed or updated their national medicines policies, bringing together all the components of the essential medicines programme. Twenty-seven global standards were developed during the biennium, 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; a global programme to combat counterfeit medicines was also initiated. Two Organization-wide expected results in the essential medicines area of work were only partly achieved. These relate to the promotion of efficient and secure systems for medicines supply; and the strengthening and promotion of global norms, standards and guidelines for the quality, safety and efficacy of medicines.

47. **Essential health technologies (BCT).** The WHO bulk procurement scheme facilitated the provision of high-quality HIV diagnostics to 45 Member States. In this way, the scheme achieved substantial savings while assuring quality. Advice was provided to several Member States on strategies for HIV testing, including the selection and use of test kits. World Blood Donor Day was celebrated in the majority of countries in all regions and was marked by a global event in Ottawa. As part of World Blood Donor Day, the Global Initiative on Safe Blood for Safe Motherhood was launched. During the biennium an additional 29 countries developed national blood policies and strategic plans for blood safety. In the area of injection safety, 44 additional countries implemented comprehensive policies and strategies on injection safety. Two Organization-wide expected results in the essential health technologies area of work were only partly achieved. These relate to the provision of support to build capacity to develop standard procedures, and the use of model lists of essential medical devices; and promotion and support for the establishment of components of electronic information for use in health-care systems.

Determinants of health

48. Eight areas of work are included in this group.[1]



49. **Food safety (FOS).** More than 238 risk assessments were conducted in the area of microbiological and chemical food hazards, thus providing timely scientific advice and guidance to Member States in their efforts to increase capacity to manage foodborne health risks. In 2006 a strategy to estimate the global burden of foodborne diseases was implemented, and an international expert advisory group was established to provide estimates of all relevant pathogenic and chemical causes of disease. The dissemination of WHO's "five keys to safer food" was also expanded at country level. In addition, the Codex Trust Fund supported the participation of 338 national food safety experts from 100 countries in 34 meetings of the Codex Alimentarius Commission. Two Organization-wide expected results in the food safety area of work were only partly achieved. These relate to the strengthening of foodborne disease surveillance and food-hazard monitoring and response programmes, and the establishment of international networks; and the provision of technical guidance to assess and manage the risks and benefits associated with products of new food technologies.

50. **Gender, women and health (GWH).** The strategy for integrating gender analysis and actions into the work of WHO was noted with appreciation by the Health Assembly in resolution WHA60.25. Implementation of the strategy began during the biennium, and collaborative mechanisms were designed for the necessary joint planning and delivery of technical support. WHO played a greater role in interagency actions as part of the United Nations' response to sexual and gender-based violence in crises and emergency settings. Evidence was compiled concerning links between gender equality and health in areas such as HIV/AIDS, malaria, occupational health, tobacco control, ageing and communicable diseases. Additional partnerships were established to devise methods and tools for scaling up gender analysis in WHO; harmonization of relevant efforts was also improved. Three

[1] 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).

Organization-wide expected results in the gender, women and health area of work were only partly achieved. These relate to translation of evidence into standards and strategies; improved skills and capacities of WHO staff to integrate gender perspectives in their work; and improved public understanding of gender-based issues through advocacy.

51. **Health and environment (PHE).** The development of the global plan of action on workers' health 2008–2017, and its endorsement by the Sixtieth World Health Assembly,[1] triggered a number of regional initiatives and country-level actions in the area of environment and health in order to tackle issues affecting workers. Global burden of disease assessments were conducted during the biennium in relation to environmental health, and regional capacity was enhanced in respect of the following: quality management of drinking-water, 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 development of healthy settings approaches. All three Organization-wide expected results in the health and environment area of work were fully achieved.

52. **Health promotion (HPR).** Much of WHO's work with countries involved capacity-building, with support provided to university courses, in-service courses, and ad hoc courses at regional level. Countries were also provided support to progress towards sustainable financing of health promotion, although overall investments in health promotion remained low and modes of financing were limited. Important publications on the theory and effectiveness of health promotion were released; however, there continued to be few examples of developing country studies. Other areas covered by WHO's work on health promotion include school-based health promotion and surveillance of health behaviour. Two Organization-wide expected results in the health promotion area of work were only partly achieved. These relate to the validation and dissemination of evidence on the effectiveness of health promotion strategies and interventions, and the establishment of a global partnership to support countries in implementing recommendations of the Sixth Global Conference on Health Promotion (Bangkok, 7–11 August 2005).

53. **Nutrition (NUT).** The launch in April 2006 of the WHO Child Growth Standards was a major landmark. The global dissemination of the Standards, and associated efforts to build regional capacity, progressed; and 83 countries are already implementing the Standards. WHO/FAO guidelines on food fortification with micronutrients were released,[2] covering both public health and technological matters. The drafting of a joint statement on community-based management of severe acute malnutrition by WHO, WFP, UNICEF, and the United Nations System Standing Committee on Nutrition was another important achievement with the potential to have a positive impact on child mortality. The first phase of the project entitled "Landscape Analysis on Countries' Readiness to Act in Nutrition" was launched in 36 countries with a high prevalence of stunting. One Organization-wide expected result in the nutrition area of work was only partly achieved. This relates to the provision of technical and policy support to improve nutrition in crises and in special circumstances.

54. **Tobacco (TOB).** The number of countries that are Parties to the WHO Framework Convention on Tobacco Control increased rapidly; at the same time, the transition of the interim secretariat for the Framework Convention to the permanent Convention Secretariat was also completed successfully. At country, regional, and global levels, WHO's awareness-building activities and technical support for

[1] Resolution WHA60.26.

[2] *Guidelines on food fortification with micronutrients.* Geneva, World Health Organization and Food Agriculture Organization of the United Nations, 2006, in press.

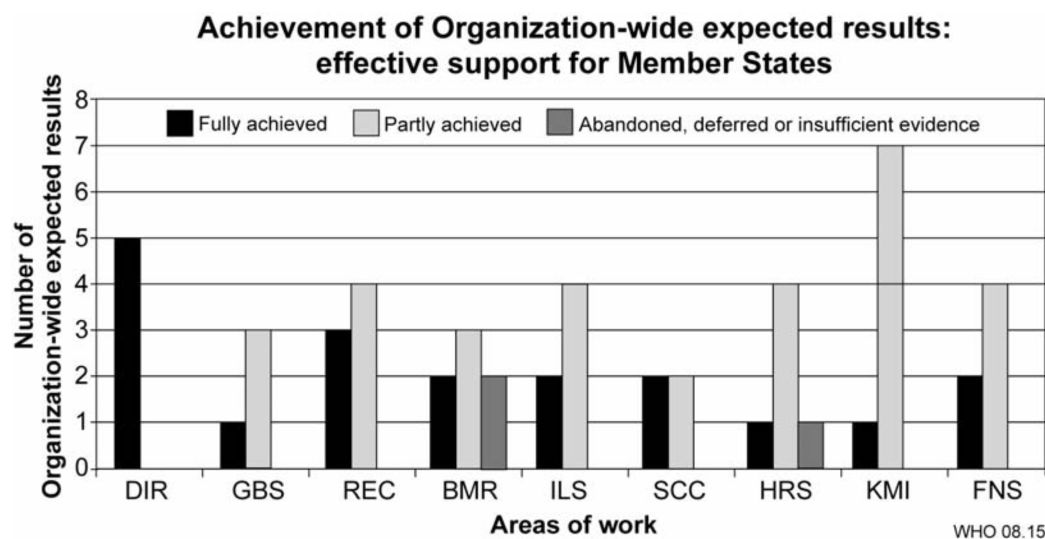
the implementation and ratification of the Framework Convention enabled Member States to become Parties to the Convention. By the end of the biennium, cost-effective tobacco control policies were being implemented by a large number of countries. A surveillance system covering the vast majority of Member States was established and important WHO policy recommendations were developed. All six Organization-wide expected results in the tobacco area of work were fully achieved.

55. **Violence, injuries and disabilities (INJ).** WHO raised awareness of, and promoted ways of addressing, threats associated with road traffic crashes, violence and injuries. The Organization also worked towards improving the life of people with disabilities. A number of important partnerships were created or reinforced at all levels, including global and regional networks of health ministry focal points, the United Nations Road Safety Collaboration, the Violence Prevention Alliance and partnerships with one or more United Nations agencies. The First United Nations Global Road Safety Week, dedicated to young road users, was celebrated in almost all countries of the world; as part of the event, young leaders from 100 countries attended the World Youth Assembly for Road Safety (Geneva, 23–29 April 2007). Several countries received support in setting up programmes to strengthen prevention and improve emergency and rehabilitation services. A number of important normative documents were also elaborated during the biennium. All seven Organization-wide expected results in the violence, injuries and disabilities area of work were fully achieved.

56. **Communicable disease research (CRD).** Research into community involvement in health-care delivery continued to produce important results. Large, multicountry studies demonstrated that community-directed interventions in Africa can be expanded to cover the co-implementation of up to five interventions, including home treatment of malaria and distribution of insecticide-treated bednets. WHO 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. Two Organization-wide expected results in the communicable disease research area of work were only partly achieved. These relate to development of tools for prevention and control of infectious diseases; and the framing and validation of public-health policies for implementation of prevention and control strategies.

Effective support for Member States

57. The group comprises nine elements, often considered as the enabling areas of work.[1]



58. **Direction (DIR).** The Organization successfully managed the aftermath of a major, unforeseeable tragedy, namely the sudden death of Dr Lee Jong-wook, and continued to provide appropriate direction and support to Member States during the period of transition before a new Director-General was appointed. During the biennium, Member States were encouraged to endorse several significant strategies and global plans of action, notably the global strategy on 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] All five Organization-wide expected results in the direction area of work were fully achieved.

59. **Governing bodies (GBS).** The services provided ensured the smooth functioning of regular governing body meetings at headquarters and in the regions. Additional governing bodies meetings were organized and held, including special sessions of the Executive Board and the Health Assembly in 2006 and two Conferences of the Parties to the WHO Framework Convention on Tobacco Control. Informal consultations were increasingly used in order to ensure increased cooperation, communication and policy coordination among Member States and the Secretariat. Three Organization-wide expected results in the governing bodies area of work were only partly achieved. These relate to the adoption of resolutions that focus on policy and strategy and provide clear orientations to Member States and the Secretariat; improving communication between Member States,

[1] 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).

[2] Resolution WHA59.19.

[3] Resolution WHA60.25.

[4] Resolution WHA60.26.

Executive Board members and the Secretariat; and conducting governing body meetings in the official languages of WHO.

60. **External relations (REC).** Effective consultation and coordination with organizations in the United Nations system were demonstrated during the biennium, with WHO participating in the United Nations reform initiative in eight pilot countries. The Organization increased its activity with regional development banks, and regional development forums and institutions. Four Organization-wide expected results in the external relations area of work were only partly achieved. These relate to securing WHO's resource base; improving the added value of private sector involvement in public health programmes; improving transparency and access to knowledge about nongovernmental organizations; and extending the Health Academy programme.

61. **Planning, resource coordination and oversight (BMR).** WHO's results-based management framework was revised during the biennium, with a move from a biennial to a six-year strategic planning cycle and the introduction of more inclusive horizontal planning and programming through the shifting of the programmatic focus from 36 areas of work to 13 strategic objectives. Record funding was mobilized, allowing for robust funding of the Programme budget 2006–2007. The Eleventh General Programme of Work, 2006–2015 was approved[1] and the Medium-term strategic plan 2008–2013 was endorsed;[2] in its appropriation resolution,[3] the Health Assembly approved the Programme budget 2008–2009. Three Organization-wide expected results in the planning, resource coordination and oversight area of work were only partly achieved. These relate to the application of the revised managerial framework and related processes; the application of a global system for planning and administration of voluntary resources; and sustaining the culture and practice of results-based management at all levels of the Organization. One Organization-wide expected result relating to the establishment of a globally compatible programme management information system was abandoned in order to focus efforts on the development of the global management system. There was insufficient evidence to determine the extent of achievement for another Organization-wide expected result relating to the strengthening of capacity for quality assurance services.

62. **Infrastructure and logistics (ILS).** Several office extensions, renovation work and construction projects were carried out, including completion of the new WHO/UNAIDS building at headquarters and new office buildings and refurbishments in the Region of the Americas and the South-East Asia and Eastern Mediterranean regions. WHO took occupancy of the new global service centre in Kuala Lumpur in late 2007, and the capital master plan – providing a 10-year picture of the Organization's global infrastructure needs – was finalized and noted by the Health Assembly, which approved the budget for capital expenditure in the appropriation resolution.[3] Negotiations with airlines allowed for the use of more favourable routes and pooling with sister agencies, allowing for considerable savings on air fares. Four Organization-wide expected results in the infrastructure and logistics area of work were only partly achieved. These relate to the resource-effective and efficient operation of logistics support functions; the effective provision of infrastructure and logistic services to global governing bodies and technical meetings; the improved security and safety of grounds and premises; and improved real estate facilities.

[1] Resolution WHA59.4.

[2] Resolution WHA60.11.

[3] Resolution WHA60.12.

63. **WHO's core presence in countries (SCC).** At the end of the biennium 80% of country offices were connected to the Global Private Network, thereby greatly enhancing communication across the Organization. All regions agreed to move towards a corporate competitive-selection process for the recruitment of heads of WHO country offices. Delegation of authority was enhanced in some regions. The Fourth Global Meeting of Heads of WHO Country Offices with the Director-General and Regional Directors was organized and held in late 2007. Two Organization-wide expected results in this area of work were only partly achieved. These relate to improved core presence and capability to implement WHO's strategic agenda at country level; and the strengthening of mechanisms for effective implementation and monitoring of WHO country focus and decentralization policies.

64. **Human resources management in WHO (HRS).** Various improvements were made in human resources management including the fast-track selection processes, electronic testing, electronic tools, and the grouping of recruitments for similar positions. Support towards the establishment of the global service centre was provided through post classification, recruitment and outreach, career development and review of pay and benefits. Four Organization-wide expected results in the human resources management area of work were only partly achieved. These relate to the establishment of a new global human resources information system; the launching of effective learning programmes; the maintenance of procedures and systems for staff recruitment and meeting contractual obligations; and the establishment of management systems for staff security. Another Organization-wide expected result, relating to implementation of staff rotation and mobility, was deferred.

65. **Knowledge management and information technology (KMI).** The global information and communication technology strategy was issued during the biennium, and the Health InterNetwork Access to Research Initiative and its two sister programmes provided free access to medical, environmental, agricultural and nutritional information online to some 4500 institutions in more than 100 Member States. Seven Organization-wide expected results in the knowledge management and information technology area of work were only partly achieved. These relate to development of knowledge management policies and strategies; integration of WHO's information products into learning systems; the design and implementation of a unified information management and technology architecture at WHO; the establishment of appropriate technology infrastructure and information strategies; the application of WHO's information products and tools; cost-effective provision of existing technologies to the Organization; and having a fully operational global management system in place.

66. **Budget and financial management (FNS).** Progress was made in preparing for the new budget and financial management and accounting systems to be introduced as part of the global management system. All statutory reporting deadlines were met during the biennium. Compliance with internal and external audit recommendations was reasonable, and adequate internal controls were maintained. Good progress was recorded in implementing new accounting practices (International Public Sector Accounting Standards), and earnings on interest showed good performance. Four Organization-wide expected results in the budget and financial management area of work were only partly achieved. These relate to the preparation of policy and guidance for the implementation of functions in line with the global management system; the drawing up of integrated budget estimates, and the performance of projections, monitoring and reporting in respect of income and expenditure; the preparation of statutory and other financial reports and their submission to the Health Assembly; and the implementation of a financing strategy for integrated budget management.

LESSONS LEARNT AND ACTIONS REQUIRED TO IMPROVE PERFORMANCE

67. The following lessons learnt and actions required in order to improve performance relate only to managerial and organizational issues; those relating to specific technical matters are included in the full report.

68. The major lessons learnt by the Secretariat in the biennium 2006–2007 include the following:

- extensive briefings and broadly based consultations with Member States are effective mechanisms to facilitate the understanding of complex agenda items ahead of the governing body meetings;
- advocacy, information and dissemination of WHO materials all play an indispensable role in promoting policies with Member States and partners;
- coordinated planning across all three levels of the Organization is instrumental to harmonized implementation of programmes;
- country-level capacity for putting global or regional strategies into operation remains limited for some areas of work;
- indicators used were sometimes not amenable to measurement and targets were, in certain cases, overly ambitious;
- administrative and procedural constraints continued to hinder expansion of activities in many areas of work and locations;
- outsourcing and offshoring of services can reduce operational costs in some offices.

69. Actions required to improve performance include:

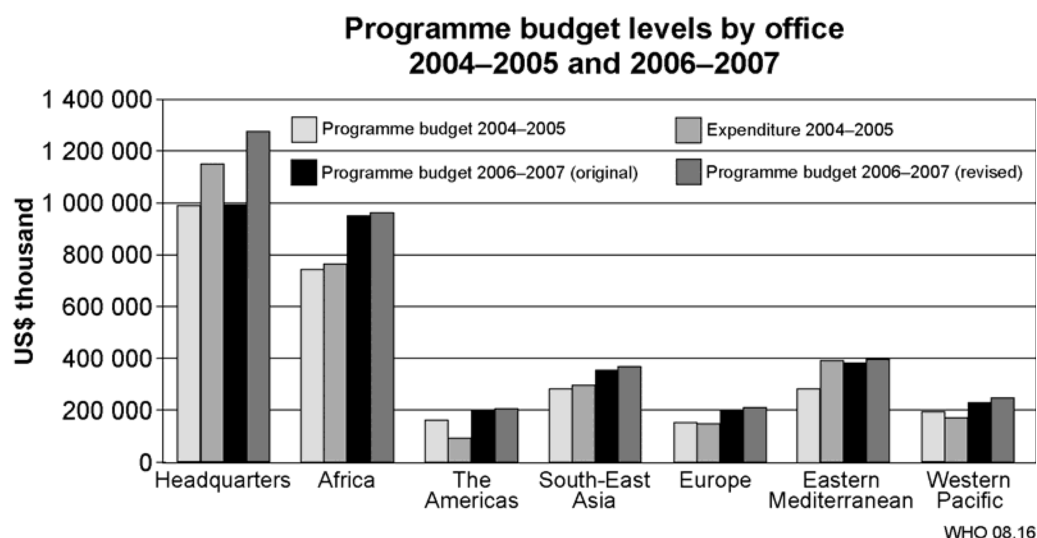
- building the capacity of WHO country teams to deal with partnerships and the United Nations' alignment and harmonization agenda;
- enhancing tools and methods to review WHO's performance in countries;
- strengthening the capabilities of regional and country offices to communicate effectively with the public and the media;
- improving coordination and cohesion with bodies in the United Nations system, bilateral agencies, development banks, nongovernmental organizations, civil society and academia;
- engaging in discussion with main donors in order to seek more flexible and predictable funding in line with agreed priorities established in WHO's Programme budget;
- revising performance indicators in the Medium-term strategic plan 2008–2013 in order to ensure measurability;
- streamlining administrative and management policies and procedures in order to enhance effectiveness and facilitate scale up activities, especially at country level;

- further streamlining human resource procedures in order to accelerate recruitment;
- strengthening the WHO budget and resource coordination function;
- increasing the capacity of technical units to analyse available resources, expenditure and financial implementation rates.

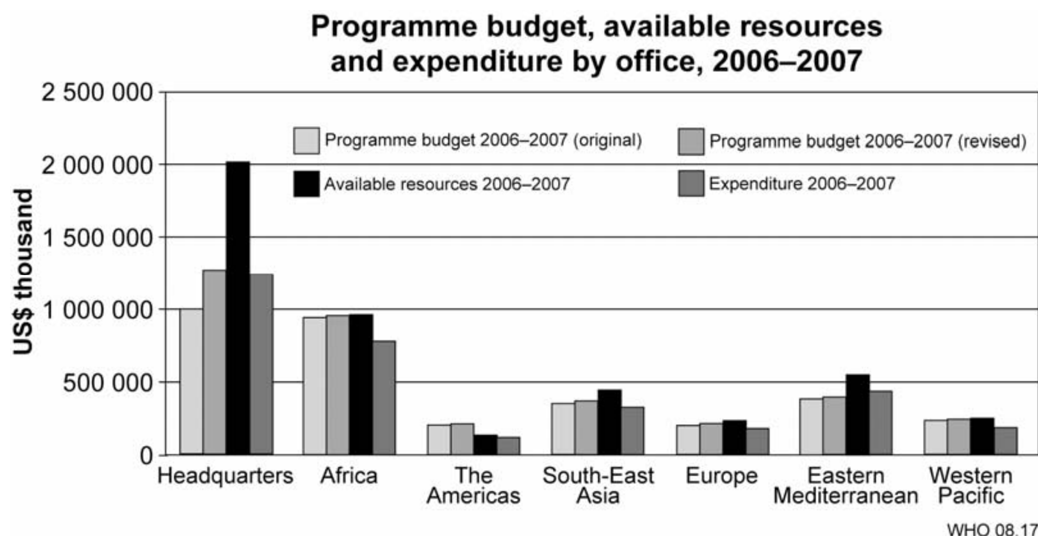
FINANCIAL IMPLEMENTATION

70. 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.

71. 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.



72. Despite a record level of expenditure for programme implementation, which increased by 14% in relation to the biennium 2004–2005, financial implementation was unable to keep pace with the rapid budget growth experienced during the biennium 2006–2007. 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.



73. Financial resources available to the Organization for programme activities for the biennium 2006–2007 amounted to US$ 4257 million. A significant amount – US$ 1600 million – is therefore available to be carried over for programme activities during the biennium 2008–2009. Analysis of implementation of the Programme budget 2006–2007 reveals the following:

- Funding of the programme budget was, to a large extent, earmarked and unevenly apportioned between programmes and major offices.
- The regular budget represented only 21% of actual income compared with 29% in the biennium 2004–2005.
- One consequence of WHO's increasing reliance on voluntary resources is that a substantial amount of funding is likely to be carried over from one biennium to the next. Moreover, such funds are essential in order to ensure the Organization's uninterrupted functioning, particularly with regard to the confirmation of staff contracts. It is difficult to estimate the minimum amount that must be carried over from one biennium to another in order for the Organization to operate efficiently. This is because the moment at which voluntary funds are received varies, the distribution of funds is uneven as a result of earmarking, and certain funds are held within partnerships.
- 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.

- Rapid growth in health sector funding not only presents challenges for WHO's implementation capacity, but also puts a strain on health ministries and other partners and counterparts with which WHO works.

- 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.

- Resources received for partnerships housed within WHO and resources for responding to disease outbreaks and crises have an impact on the implementation rate; however, neither of these categories can be controlled tightly by the Secretariat since partnerships, by definition, are collaborative arrangements, while outbreak and crisis response is driven by external circumstances. During the biennium 2006–2007, income growth for these two categories had a significant impact on the overall budget. In future, the differentiation between the various segments of the programme budget will be improved by better separating the budgets and income streams of the different categories.

- The earmarking of much of the funding provided to the Organization represented another major constraint; despite robust funding overall, certain activities were underfunded as a result. Although income grew substantially during the biennium 2006–2007 compared with the biennium 2004–2005, growth was not even across all areas of work or between major offices, and the alignment of available resources with the programme budget did not improve.

74. The expenditure split between headquarters and the regions remained unchanged between the bienniums 2004–2005 and 2006–2007 (headquarters 38%, regions and countries 62%). It is hoped that a number of administrative improvements – most notably involving reform of human resources management and streamlined recruitment processes, as well as the introduction of the global management system – will improve the implementation rate in the longer term.

75. 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 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.

76. 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.

77. 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.

78. Building on the positive experience of the advisory group and the corporate account mechanism, a core voluntary contribution fund has been set up. This is managed in a transparent and accountable manner, ensuring provision of financing to close critical funding gaps for strategic objectives at headquarters and in the regions. The fund 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.

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	Transfers 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			Voluntary contributions			Total financing		
	Programme budget	Expenditure	%	Programme budget	Expenditure	%	Programme budget	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	
Information Technology Fund	10 000	9 850		15 000	27 188		25 000	37 038	
Security Fund	3 000	3 257		20 000	26 450		23 000	29 707	
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	4	0	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		**113**	**77**	**11**	**201**

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