WORLD HEALTH ORGANIZATION

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WHO programmes 2000-2001

Report by the Secretariat

1. This report was submitted to the Executive Board at its 110th session. At the request of several members the item has been included on the agenda of the 111th session, in order to give the Board a further opportunity to review the evaluation.

2. The biennium 2000-2001 has seen significant changes in the overall managerial process, impacting on the way WHO plans, implements, monitors and evaluates its work. The present report summarizes key activities during the biennium and examines some of the challenges for the future. A more detailed report of achievements, enabling and constraining factors and lessons learned has also been compiled.[1]

BACKGROUND

3. Work on the Proposed programme budget 2000-2001 was far advanced when the Director-General took office in July 1998. The draft programme budgets had already been prepared for presentation at the meetings of the regional committees. Aware that budgeting is a powerful tool for Organization-wide change and renewal, the Director-General undertook to make changes in the process.

4. The work of the Organization was grouped into nine broad themes. Headquarters and some of the regional offices were reorganized to reflect the strategic emphases. The themes became the budget appropriation sections, thus establishing close links between strategy, organizational structure, budget and accountability.

5. Management and administrative support functions have been streamlined in order to maximize resources available for programme implementation, and to improve responsiveness of administrative processes to programme needs. Efficiency savings to the amount of US$ 50 million were made in travel costs, procurement, fellowships, study tours and publications. These funds were then reallocated to five priority areas: malaria, tuberculosis, HIV/AIDS, mental health, and strengthening of health systems.

[1] Implementation of the Programme budget 2000-2001: contributions from WHO regions and headquarters. Document PME2002/2, available upon request.

6. To instil a results- or outcome-based culture, the expected results in the Proposed programme budget were revised to set out only interventions by the Secretariat, thus distinguishing its manageable interest from that of Member States. A common minimum data set was introduced to ensure consistency in reporting across the Organization.

7. An Organization-wide framework for evaluation was drawn up. During 2000-2001, two external evaluations were carried out within this framework and the findings reported to the Programme Development Committee of the Executive Board at its eighth meeting.[1]

8. The areas of strategic focus first outlined in the Programme budget 2000-2001 were clarified when the WHO corporate strategy was endorsed by the Executive Board at its 105th session.[2] The Executive Board identified four strategic directions that provide a framework for focusing technical work:

(1) reducing excess mortality, morbidity and disability, especially in poor and marginalized populations;

(2) promoting healthy lifestyles and reducing risk factors to human health that arise from environmental, economic, social and behavioural causes;

(3) developing health systems that equitably improve health outcomes, respond to people's legitimate demands, and are financially fair;

(4) framing an enabling policy and creating an institutional environment for the health sector, and promoting an effective health dimension to social, economic, environmental and developmental policy.

9. The main achievements of the biennium are summarized below, as set out in the Programme budget 2000-2001.

COMMUNICABLE DISEASES

10. It is estimated that communicable diseases kill 11 million people annually. The overall focus of WHO's work on communicable diseases in the biennium 2000-2001 has been to intensify global and country level efforts for disease control by catalysing global partnerships between governments, international organizations, donor agencies, foundations, nongovernmental organizations and private entities.

11. In the biennium under review, WHO has created global partnerships to roll back malaria, and to stop tuberculosis. The Global Tuberculosis Drug Facility, for example, which built on the work of the Stop TB partnership, was launched in 2001 to grant medicine supplies to governments and nongovernmental organizations.

12. WHO also formed partnerships with pharmaceutical companies to combat African trypanosomiasis. In 2000, a global alliance to eliminate lymphatic filariasis brought together some

[1] Documents EBPDC8/2 and EBPDC8/3.

[2] See documents EB105/3 and EB105/2000/REC/2, Summary record of the first meeting.

30 international organizations, with WHO providing the secretariat. Through this alliance, manufacturers provide drugs free of charge, and the mass drug-administration strategy makes the drugs accessible to more than 20 million people in Africa.

NONCOMMUNICABLE DISEASES

13. During the past biennium WHO focused attention on four main groups of diseases and their risk factors, namely, cardiovascular diseases, diabetes, cancer and chronic lung diseases. These conditions share common risk factors.

14. A framework for application of a tool for surveillance of noncommunicable diseases was developed. The tool defines core variables for surveys, surveillance and monitoring, and offers guidance for low- and middle-income countries on initiation of control of noncommunicable diseases. It also provides standardized materials and methods as part of technical collaboration with countries, especially those lacking resources.

15. Management tools for tackling cancer, chronic lung diseases, diabetes and cardiovascular diseases have been developed, as have guidelines for policy-makers and health-care professionals on improving the delivery of preventive and clinical management. National and international experts were sought and engaged, and the opportunities offered by shared networks and resources were used to identify common approaches for managing chronic conditions and to reinforce adherence to treatment. The best practices and policies for long-term care were also reviewed.

FAMILY AND COMMUNITY HEALTH

16. By the end of 2001, the Integrated Management of Childhood Illness had been introduced or implemented in over 100 countries, and over 40 of these countries had initiated community-based activities for improving child health and development. Work to reduce the practice of female genital mutilation was also intensified and consolidated, and culminated in four manuals, one on advocacy and three on training health-care workers.

17. The Making Pregnancy Safer initiative began work in 10 countries, with the goals of increasing access of mothers and newborns to health services, and improving quality of care. Guidelines were drawn up on integrated management of pregnancy and childbirth, and documentation on improving access to quality care in family planning was revised to incorporate the latest scientific developments. Operations research in maternal health, family planning, reproductive tract infections, and sexually transmitted infections was carried out in all regions in order to provide evidence for interventions to improve reproductive health services.

18. WHO’s support for combating HIV/AIDS within the health sector was scaled up, with a focus on both prevention and care. WHO’s contribution to tackling HIV/AIDS in Africa was intensified by providing enhanced support to countries in sub-Saharan Africa particularly affected by HIV/AIDS.

SUSTAINABLE DEVELOPMENT AND HEALTHY ENVIRONMENTS

19. A policy framework on health in poverty reduction was endorsed by the Executive Board at its 105th session,[1] and health was placed on the agenda of the United Nations General Assembly special session on Social Development (Geneva, 2000), and the Third United Nations Conference on Least Developed Countries (Brussels, 2001). In order to promote policy coherence between health and trade sectors, the relationship between health risks and international trade issues was analysed in collaboration with WTO. Frameworks were also elaborated for analysis of the economic dimensions of globalization and health, of global public goods for health, and of global health governance. A human rights dimension was integrated in all WHO work in general, and in assessing the responsiveness of health systems in particular.

20. Normative standards and guidelines were drawn up for nutrition, energy requirements of all age groups, vitamin and mineral requirements, management of nutrition in major emergencies, and safe levels of vitamin A in pregnant women and children, in addition to preparation of the global strategy for feeding infants and young children. Support was provided to countries in the Horn of Africa for building up food and nutrition security, and to over 50 countries for strengthening national nutrition policies and programmes.

21. As part of WHO's action to protect the human environment, more than 250 specific chemical and other high-risk pollutants were evaluated during the biennium and the findings published. Amendments to WHO's guidelines for drinking-water quality were also finalized and published, and guidelines issued for air quality at global and regional levels. Member States are now using the guidelines to develop national regulatory instruments. In addition, the global food safety strategy was finalized through a consultative approach involving experts, Member States and relevant nongovernmental organizations, and subsequently endorsed by the Executive Board at its 109th session.[2]

22. A shared vision of emergency and humanitarian action, its mission, instruments and global strategy was created across WHO. Interventions were conducted in more than 50 emergencies around the world, with support from donors. These interventions improved working relationships within WHO and between WHO and other organizations, and enhanced teams at country, regional and global levels.

SOCIAL CHANGE AND MENTAL HEALTH

23. The year 2001 was also the year of mental health. Mental health was also the theme for *The world health report 2001*, World Health Day 2001; and the ministerial round tables during the Fifty-fourth World Health Assembly. As a result, mental health has become a priority on the health agenda of Member States.

24. Work on healthy ageing in 2001 involved preparation of WHO's contribution to the United Nations Second World Assembly on Ageing (Madrid, 2002). Promotion of diet and physical activity to prevent noncommunicable diseases was also initiated, including preparations for World Health Day 2002 with the theme "Move for health". The programme on substance abuse has compiled and

[1] See documents EB105/5 and EB105/2000/REC/2, Summary record of the first meeting.

[2] See document EB109/2002/REC/2, Summary record of the fourth meeting, third section.

disseminated a global database on alcohol consumption, prepared a multinational study on drug injecting and on use of amphetamine-type stimulants, and launched a global initiative on the primary prevention of substance abuse.

25. The draft of the world report on violence and health was prepared after briefings and regional consultations. WHO's first strategy for preventing traffic injury was also elaborated, which will provide the foundation for activities on traffic-injury epidemiology and prevention for the next five years. WHO also provided support to the United Nations Special Rapporteur in monitoring implementation of health-related aspects of the United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities, and a report based on the response of governments was issued.

26. Strategies and programmes to prevent blindness and deafness were further developed and strengthened. In the case of trachoma, 17 endemic countries have started implementing the WHO-recommended SAFE strategy (Surgery for trichiasis, Antibiotics, Facial cleanliness and Environmental improvement). These and other activities have been carried out in the framework of strong partnerships, particularly with Vision 2020 – the Right to Sight.

27. The Fifth Global Conference on Health Promotion (Mexico D.F., 2000) reviewed best practices and endorsed work for national capacity building. The XVII World Conference on Health Promotion and Health Education (Paris, 2001) launched a global forum for health promotion dialogue with the International Union for Health Promotion and Education and other partners. WHO continued to foster effective school health programmes, in the context of health-promoting schools and the joint WHO, UNESCO, UNICEF and World Bank FRESH initiative (Focusing Resources on Effective School Health).

HEALTH TECHNOLOGY AND PHARMACEUTICALS

28. WHO's activities have focused on the four components of its strategy for improving access to essential drugs and other medicines: rational selection of medicines, affordable prices, sustainable financing, and reliable supply and delivery systems. Medicine selection has been improved by updating the procedures of the Expert Committee on the Use of Essential Drugs, and by increasing the extent to which selection is based on evidence. WHO encouraged lower medicine prices in poor countries by advocating differential pricing and by making price information widely available. It also raised awareness of certain provisions of WTO's Agreement on Trade-Related Aspects of Intellectual Property Rights which affect the affordability of medicines.

29. Voluntary contributions in support of eradication of poliomyelitis increased from nearly US$ 160 million in 1998-1999 to US$ 392 million in 2000-2001. Although the target of eradicating poliomyelitis in all regions by the end of 2001 was not met, two of six WHO regions were certified poliomyelitis-free, and the disease remained endemic in only 10 countries. The commitment of WHO and the United Nations led to greater dedication of partners, which had a direct impact on eradication efforts.

30. One of the strategic objectives of the Global Alliance for Vaccines and Immunization (GAVI) is to increase the use of new or underutilized vaccines, including hepatitis B and *Haemophilus influenzae* type b vaccines. This meant accelerating introduction of hepatitis B vaccine, which was accomplished through funding from the Vaccine Fund, the Gates' Foundation Children's Vaccine Program, and USAID. In line with the joint UNICEF/WHO statement that advocated use of safe-injection

technologies, auto-disable syringes are now systematically provided to all countries receiving support from GAVI and from the Vaccine Fund. World Health Day 2000 raised global awareness of blood safety, and several regional offices provided support to countries in formulating national plans to ensure quality and safety of the blood supply.

31. Launching of the project on HIV/AIDS diagnostic support raised awareness and ensured the development of expertise. Prequalification of diagnostic tests is now in place, and WHO bulk purchasing has resulted in much-reduced prices for HIV tests. In addition, the Safe Injection Global Network, a global collaborative effort, makes injection kits available for drugs, vaccines and other injectables.

EVIDENCE AND INFORMATION FOR POLICY

32. New lifetime tables were estimated for all countries and published in *The world health report 2001*. The International Digest of Health Legislation became available on the Web in May 2000. More than 70 countries took part in the creation and field-testing of the International Classification of Functioning, Disability and Health, which was the first such classification. The concept of health-system responsiveness was devised, and methods to assess it were developed and further refined after an analysis of 60 country surveys, undertaken as part of the WHO multicountry survey 2000-2001. This work was complemented by efforts to reach consensus on definition of both critical functions for effective operation of health systems and methods for assessing health-system performance. Results were published in *The world health report 2000* and included composite indicators of the performance of national health systems for WHO Member States. This work aroused much interest – and critical comment – from the Executive Board at its 107th session. An extensive process of consultation, together with peer review of the methodology, was initiated by the Director-General.

33. Two volumes of the *Bulletin of the World Health Organization* were published in 2000 and 2001. Library services have been expanded to include a desktop "virtual health library" on WHO's web site, and access to the full text of all WHO documents is available through the WHOLIS database. WHO's web site (www.who.int) has been redesigned to improve navigation and access to information is in French, Spanish and English; use of the web site has grown to some 15 million hits each month.

34. WHO increasingly focused on the organization of health services. Conceptual frameworks were designed for assessing and improving provider performance, for measuring coverage of key health interventions, and for categorizing health-care delivery models. A database was compiled of WHO collaborating centres in the area of research policy and promotion, and networking and partnerships were established between key organizations involved in health research. The International Conference on Health Research for Development (Bangkok, 2000) was organized, and the International Awards to Support Cooperation in Health Research were administered by WHO.

35. The Commission on Macroeconomics and Health, established in 1999 to examine the extent to which ill-health contributes to individual deprivation and poverty and to the underdevelopment of societies, published a report in late 2001 that provided important guidance for WHO's follow-up in local, national, regional and global settings.

EXTERNAL RELATIONS AND GOVERNING BODIES

36. A number of mechanisms have been introduced to help those responsible for WHO's governance to exercise this function, including extensive briefings for staff of the permanent missions in Geneva and retreats for members of the Executive Board. Implementation of a corporate approach to securing voluntary contributions improved alignment of support with the Programme budget. Guidelines on interaction with the private sector were drawn up and have facilitated major in-kind drug contributions to several disease control programmes.

37. The Meeting of Interested Parties was organized in mid-2001 as a formal consultative exercise. This was the first such meeting to cover the entire work of WHO and to involve all levels of the Organization. The Civil Society Initiative was launched in response to the need to reach a broader range of civil-society entities, with the objective of framing a WHO policy for effective collaboration, information exchange and dialogue.

38. Cooperation between WHO and the institutions of the European Union, in particular the Commission of the European Communities, has been strengthened. A new exchange of letters between WHO and the Commission was concluded in December 2000 that set out a new framework for intensified cooperation. As a consequence, policy dialogues have taken place with different Directorates-General on a range of issues, including health and poverty, accelerated action on control of major communicable diseases, health and environment, tobacco control, and sustainable development.

39. In collaboration with OAU and the Government of Nigeria, two summits of Heads of State were held at Abuja during the biennium to discuss Roll Back Malaria and efforts to tackle HIV/AIDS and tuberculosis. These summits were influential in articulating a comprehensive plan and generating the political will required for its implementation. The second global meeting of WHO Representatives and Liaison Officers (March 2001) laid the foundation for a strategy to ensure that WHO's work with countries was better focused and more effective.

GENERAL MANAGEMENT

40. As requested by resolution WHA52.20, the Financial Rules and Financial Regulations were thoroughly reviewed and revised in collaboration with Member States. The revised Rules, confirmed by the Executive Board at its 107th session,[1] and noted at the Fifty-fourth World Health Assembly,[2] have been implemented.

41. A number of reforms in management of human resources were also introduced. A new system of contracts has been developed that comes into force on 1 July 2002, and which seeks to improve and standardize the employment conditions of short-term staff. A new staff performance management and development system was launched throughout WHO on 1 January 2002. This system closely links staff performance objectives to work plans, and ensures cohesion between the work of the individual and WHO's overall commitments as reflected in the Programme budget.

[1] Resolution EB107.R6.

[2] See document WHA54/2001/REC/3, Summary record of the third meeting of Committee B, first section.

42. During 2000-2001 a WHO global private network was established that enabled all regional offices to access a global network for voice, data and image transmission. Over 90% of country offices now have access to voice, e-mail and Internet services, and all of those with an Internet connection have the means to access the Intranet at headquarters.

CABINET PROJECTS

43. One of the innovations in 2000-2001 was the creation of three cabinet projects: Roll Back Malaria; the Tobacco Free Initiative; and Partnerships for Health Sector Development. The establishment of such projects was seen as a way of rapidly creating visibility and impact in selected areas, and to create a unity of purpose throughout WHO for key issues on the Director-General's agenda.

Roll Back Malaria

44. The main benefit of designating Roll Back Malaria as a cabinet project was that it fostered a greater understanding in WHO of the problem of malaria, and led to an agreement on the actions needed to make an effective impact. The project adopted a four-prong strategy: prompt access to treatment, prevention with insecticide-treated nets, epidemic prediction and response, and malaria in pregnancy. The project has been successful in building and coordinating partnerships between international organizations, and in developing links with networks of national organizations, the private sector and nongovernmental organizations.

45. Being a cabinet project facilitated crosscutting work. For example, the prompt access to treatment team encourages governments and national Roll Back Malaria partnerships to monitor the development of parasite resistance to antimalarial drugs, to replace drugs which are no longer effective, and to increase access to effective treatment. The product development groups under the UNDP/World Bank/WHO special programme for Research and Training in Tropical Diseases, often in collaboration with industrial partners, identify potential antimalarial drugs and provide support for the necessary clinical trials and for implementing research. Similar collaboration on essential drugs and medicines led to work with regulatory authorities on such issues as drug registration and deployment in developing countries. During 2001, an extended group worked with the governments of Burundi, Ethiopia, Rwanda, South Africa, United Republic of Tanzania and Zambia on changes in policy for malaria treatment. The project also established strong links with Integrated Management of Childhood Illness, particularly in the Regional Office for Africa.

46. Roll Back Malaria has succeeded in raising awareness of malaria at high political levels and successfully placed malaria on the global agenda, as reflected by the Abuja Declaration on Roll Back Malaria in Africa (2000), and the proclamation by the United Nations General Assembly of the period 2001-2010 as the Decade to Roll Back Malaria in Developing Countries, Particularly in Africa.[1] The heightened awareness of malaria and the potential to control it, led to inclusion of the disease as one to be tackled by the Global Fund to Fight AIDS, Tuberculosis and Malaria.

[1] United Nations General Assembly resolution 55/284.

Tobacco Free Initiative

47. The Tobacco Free Initiative was launched as a cabinet project to provide global leadership and to mobilize national and international action for preventing and reducing tobacco use. By resolution WHA53.16, the Health Assembly endorsed the start of negotiations on a framework convention on tobacco control, which will be WHO's first global treaty. It is expected that the convention will be adopted in 2003.

48. The Initiative organized the first public hearings on tobacco consumption at the United Nations (2000). Also, the Ad Hoc Interagency Task Force on Tobacco Control, chaired by WHO, initiated studies on the economic implications of tobacco reduction; employment issues related to tobacco control; smoke-free policies in the United Nations workplace; smuggling; trade issues related to the framework convention on tobacco control; an economic analysis of tobacco control that focuses on demand-side issues; and privatization and illicit trade.

49. The Director-General appointed a committee of experts to review and report on the tactics used by tobacco companies in targeting United Nations activities. The Global Youth Tobacco Survey was completed in over 50 countries, and a report issued on the impact of tobacco on children and young people;[1] a report on the Convention of the Rights of the Child and its relation to tobacco was issued in 2001.[2]

50. The Tobacco Free Initiative developed an effective global network of media contacts which, in conjunction with high-profile events, ensures regular, international reporting of WHO's message on tobacco control. The "Tobacco kills, don't be duped" media advocacy project is currently active in over 20 countries, and activity related to World No Tobacco Day continues to be one of the major annual public health events.

Partnerships for health sector development

51. The purpose of the project on partnerships for health sector development was to develop a corporate approach to country work in general, and to country cooperation strategies as an instrument of organizational change in particular. It examined the way in which different parts of the Organization work with each other, with countries and with development partners. Three interrelated components were defined: to develop a more strategic approach to country work, to promote a health-sector perspective, and to strengthen WHO's dialogue and engagement with development agencies that support health-sector development. In close collaboration with regional offices, the project devised a process for formulating WHO's country cooperation strategy.

52. By the end of 2000, four "experimental" country cooperation strategies had been formulated and the institutionalization phase began. By July 2001, country cooperation strategies had been initiated in 25 countries in the six regions, and country support units had been established or strengthened at headquarters and in the regional offices.

[1] International consultation on tobacco and youth: what in the world works? Document WHO/NMH/TFI/00.1.

[2] Tobacco and the rights of the child. Document WHO/TFI/01.3 Rev.1.

LESSONS LEARNED FROM IMPLEMENTING THE PROGRAMME BUDGET 2000-2001

53. Analyses of work undertaken in 2000-2001 show that considerable progress has been made in most areas. Although all four strategic directions set for the biennium (see paragraph 8) have been actively pursued, real progress has been made primarily in strategic directions 1 and 2. More work needs to be done in relation to strategic direction 3 if WHO is to contribute optimally and improve health outcomes for the poor. In order to advance in strategic direction 4, WHO needs to help define the best ways for national policies in sectors other than health to have the greatest impact on health outcomes. This includes working with countries to take account of the findings of the Commission on Macroeconomics and Health in order to improve the well-being of the poor, and participating fully in new mechanisms in development cooperation, particularly in poverty-reduction strategies, sector-wide approaches, and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

54. Given the need to increase the impact of WHO's work at country level, the country cooperation strategy introduced during the biennium 2000-2001 is being broadened and amplified with a view to improving the Organization's performance at country level. At the start of 2002, the Director-General and Regional Directors started to develop a new *country focus* initiative. This includes plans for building-up competence within WHO to support the development of health systems, for promoting action to address poverty, for responding to the Commission on Macroeconomics and Health, for improving the capacity of WHO teams within countries, for improving the systems through which WHO country work is managed, and for enabling WHO to work more effectively with the United Nations system and other governmental and civil society partners within countries.

55. To achieve its objectives, WHO also needs to engage more consistently and coherently with partners, such as the European Commission and other organizations of the United Nations system; to position its work in the broader context of economic and social development; and to improve its responsiveness to emergencies and emerging priorities through better contingency planning.

56. Lastly, to ensure that the programme and priorities adopted by the World Health Assembly are respected and that programme and financial accountability is improved, activities supported through extrabudgetary resources need to be harmonized and better integrated with those financed from the regular budget. Systems for managing the human and financial resources available to the Organization will therefore be streamlined.

ACTION BY THE EXECUTIVE BOARD

57. The Executive Board is invited to note the above report.

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