**World Health Organization**
**Organisation mondiale de la Santé**

FIFTIETH WORLD HEALTH ASSEMBLY

Provisional agenda items 17.1 and 17.2

**A50/4**
27 March 1997

# Report of the Executive Board to the World Health Assembly on the proposed programme budget for the financial period 1998-1999 and response by the Director-General

The present document has been elaborated in conformity with Articles 3.5, 3.6 and 3.9 of the Financial Regulations of the World Health Organization. It comprises the report by the Executive Board to the Health Assembly on the proposed programme budget for the financial period 1998-1999 (Part I).

In the light of the views expressed by the Executive Board (resolution EB99.R13) the Director-General is proposing a number of changes in the original draft of the proposed programme budget for the consideration of the Health Assembly (Parts II and III). Information on cost and currency adjustments is given in order to facilitate the discussion of the proposed programme budget by the Health Assembly (Part IV).

It is therefore intended that the Fiftieth World Health Assembly should use this document as a complement to document PB/98-99, Proposed programme budget for the financial period 1998-1999.

## CONTENTS

# PART I

# REVIEW OF THE PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1998-1999 BY THE EXECUTIVE BOARD AT ITS NINETY-NINTH SESSION

## I.1 General discussion

1. In January 1997 the Executive Board reviewed the proposed programme budget for the financial period 1998-1999.[1] This was the second strategic programme budget presented to the governing bodies; the first was the programme budget for the financial period 1996-1997 prepared in response to resolution WHA46.35. In approving the strategic programme budget for 1996-1997, the governing bodies adopted a series of resolutions (EB95.R4, WHA48.25 and EB97.R4) aimed at improving the approach to programme budget preparation. They request, *inter alia*, that the 1998-1999 programme budget should establish realistic and measurable targets for WHO products and, in particular, for each health priority; improve programme evaluation on the basis of the agreed targets and of the results; further reorient resources in accordance with priorities; and present data on actual expenditure for the most recently completed biennium, for comparison. The proposed programme budget for the financial period 1998-1999 is thus the product of consolidated budgetary reform, as requested by the above-mentioned resolutions, and of the experience gained by WHO in preparation of strategic programme budgets.

2. In addition, by resolution EB95.R4, the Executive Board endorsed the concept of strategic programme budgeting on the understanding that detailed **plans of action** would be prepared nearer to the time of implementation. A first version of a plan of action was presented to the Programme Development Committee of the Executive Board and to the Executive Board in January 1995. The Board made a number of comments for its improvement. A new consolidated model of a plan of action was presented to the Executive Board in January 1997, which expressed its satisfaction and proposed that the model should be applied throughout the Organization as from 1998.

3. While welcoming the new presentation of the proposed programme budget for 1998-1999, the Board made a number of comments. One of the most remarkable achievements of the reform process was the **improvement in the structure and transparency** of the budget, particularly the addition of information boxes showing the shifts of resources at all levels and the financial tables allowing comparison between various periods. The visibility of priorities, however, might be enhanced in forthcoming budgets. The level of the budget was crucial, as the regular budget had been stretched to its limits after 15 years of zero real growth or less, and recent cuts. The budget level needed further examination, especially in view of its impact on the balance between regular and extrabudgetary funds.

4. The Board expressed concern on how to ensure that programme orientations and activities to be carried out with **extrabudgetary resources** were consistent with the Organization's mission and priorities, a question that was further complicated by the fact that when the Board approved the budget, it did not know how much extrabudgetary funding would finally be available. It was proposed that a panel should be set up at headquarters, with the participation of a Board member, to discuss such issues as production of guidelines on handling of such resources in the context of the overall priorities of WHO. The findings would be reported to the Board at its 100th session in May 1997.

[1] Document PB/98-99.

5. The Board welcomed the efforts made to define **targets**. This, together with the concept of products, reflected a new way of administering the Organization, focused on outputs. It endorsed WHO's proposals for improved and strengthened programme evaluation and, in particular, evaluation of implementation of the programme budget.

6. Resolution WHA48.26 had requested the Executive Board and the Director-General to initiate a process of biennial budgetary transfers from global and interregional activities to priority health programmes at country level, starting with 2% in 1998-1999. In resolution EB97.R4 the Board had endorsed the proposal to transfer this 2% from the global and interregional programme to country programmes, one-half for incorporating HIV/AIDS activities into the mainstream of WHO programmes and, in countries of greatest need, one-half for diseases that can be eliminated or eradicated. In this context, the Board asked for more details of the 2% shift in resources requested by these two resolutions.

7. The Board re-emphasized the importance of **priority-setting**. The meeting of the special group of the Executive Board and Global Policy Council for setting priorities (17 May 1996), recognizing the importance to the Organization of pursuing its efforts in priority areas for a longer period of time, decided to maintain the 1996-1997 priorities for the 1998-1999 biennium.[1] The Board welcomed the redirection of funds towards these priorities and requested further information on the shifts of resources and on determination of priorities at each level of the Organization. It expressed concern at divergence at the country, regional and global levels from the priorities selected for the Organization as a whole. The apparent divergences, however, were all in the field of primary health care, and the Board felt that a matrix presentation would provide greater clarity on the budget proposed for this area of work.

8. To emphasize the link between the policies of the Organization and their implementation, the Board adopted resolution EB99.R15, "WHO reform: linking the renewed health-for-all strategy with the Tenth General Programme of Work, programme budgeting and evaluation". The resolution requested the Director-General, *inter alia*,

> *... to ensure that the global policy is implemented through plans of action that will have strong international, regional and national components with revised targets and indicators, incorporating overall monitoring and evaluation;*
>
> *... to continue the preparation of the Tenth General Programme of Work closely linked with the preparation of the new policy for health for all for the twenty-first century, providing targets, revised as appropriate, that have been defined within the terms of the new policy, and showing consistency of vision and content ... .*

## I.2 Specific recommendations

9. The Board reviewed the **six appropriation sections and the 19 major programmes** comprising the programme budget proposals and made a number of specific comments which are reported in detail in the summary records of the Executive Board.[2] In particular, it asked how the maintenance of important policy areas of health in socioeconomic development could be reconciled with the discontinuation at headquarters of all posts in health policy in development. It also expressed concern that, despite the adoption of resolution WHA49.12 on the WHO global strategy for occupational health for all, there had been a drastic cut in the budget allocation for occupational health and an important reduction in the number of related posts. It queried the absence of any

[1] These priorities are: eradication of specific communicable diseases, prevention and control of specific communicable diseases, reproductive health, women's health and family health, promotion of primary health care and other areas that contribute to primary health care, such as essential drugs and vaccines and nutrition, and promotion of environmental health, especially community water supply and sanitation.

[2] See document EB99/1997/REC/2, summary records of the second to the thirteenth meeting.

text relating to "technical cooperation with countries", an area which had seen an important increase in all regions, except in the Western Pacific. It also expressed concern at the proposed increase under extrabudgetary funds in administrative costs shown in appropriation section 6. It further queried the fact that funds dedicated to countries in greatest need had decreased.

10. While commending the Director-General for the progress made in budgetary reform, the Board, in resolution EB99.R13, "Programme budgeting and priority-setting", reiterated the importance of ensuring accountability at all levels of the Organization for health outcomes in accordance with clear objectives, and expressed concern that the priorities agreed upon by the Board were not adequately reflected in the proposed programme budget for 1998-1999. It thus requested the Director-General to provide further information, and to propose a series of improvements in the programme budget as shown below.

*2. ...*

***A. Regarding budget development:***

*(1) further to develop clear statements of strategic objectives for all programmes;*

*(2) to clarify all targets in terms of measurable products, where feasible;*

*(3) to ensure that evaluation mechanisms are extended to all activities of the Organization including the use of WHO collaborating centres, and that results are reported early enough to affect future planning;*

*(4) to strengthen the critical analysis of nonfinancial factors that impede or foster achievement of objectives, outcomes, programme delivery, or products;*

*(5) to ensure that priorities recommended by the Executive Board and approved by the Health Assembly are reflected at global level and, as appropriate, regional and country levels, in a more coherent programme of work;*

*(6) to take full account of health activities and programmes under way at country level with a view to ensuring complementarity and consistency at all levels of the Organization;*

*(7) to harmonize and refine the presentation of the financial statements and the proposed programme budget to permit comparison of budgetary allocations with expenditure at each specific programme level;*

***B. Regarding priority-setting:***

*(1) to consider revising the 1998-1999 proposed programme budget for presentation to the Fiftieth World Health Assembly to take into account the comments of the Executive Board and better to reflect, at all levels of the Organization, the priorities recommended by the Board and adopted by the Health Assembly;*

*(2) to provide an explanatory report to the Fiftieth World Health Assembly which:*

*(a) sets out in detail the specific reallocation of funds to achieve the 2% transfer from global and interregional activities to priority programmes at country level (as requested in resolutions WHA48.26 and EB97.R4);*

*(b) indicates how the priorities recommended by the Executive Board were enhanced by the proposed programme budget for 1998-1999,[1] including the amounts transferred at each level of the Organization to identified programme priorities and to countries in greatest need, and the sources of the budget from which those funds were transferred;*

*(c) presents administrative costs associated with programme delivery for the major and specific programmes;*

*(3) to develop an analytical framework to expedite setting and revision of priorities based on WHO's mandate and on global health determinants and challenges;*

*(4) to propose to the Executive Board a specific process for developing priorities for the Organization as a whole;*

***C. Regarding budgetary savings:***

*(1) to propose a systematic policy for savings stemming from improved efficiency which, based on a review of all major programmes, identifies economy measures, administrative savings and new ways of programme delivery with a view to ensuring that best value is attained for available resources in improving the quality of international health, and that maximum funds are allocated to priority programmes;*

*(2) to seek a savings target through improved efficiency for the proposed programme budget for 1998-1999 over the biennium that could contribute to reallocations for higher priority programmes and/or cost containment;*

***D. Regarding multilateral coordination:***

*(1) to seek, taking into account WHO's comparative advantage as the leader in global health, and with a view to making savings through the elimination of duplication and overlapping, and maximum coordination with other United Nations and multilateral bodies, including exploration of greater use of common services and premises where appropriate;*

*(2) to explore additional mechanisms to make savings, such as the development of new partnerships within the United Nations system, with nongovernmental organizations and with WHO collaborating centres.*

[1] Document EB98/1996/REC/1, Annex 2.

# PART II

# THE DIRECTOR-GENERAL'S PROPOSALS TO THE WORLD HEALTH ASSEMBLY ON THE PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1998-1999 IN RESPONSE TO THE EXECUTIVE BOARD

11. In adopting resolutions EB99.R13 and EB99.R15, the Board clearly indicated the orientations to be given to the proposed strategic programme budget for 1998-1999 and for future biennial programme budgets. It also asked me to clarify a number of issues and to effect some changes with a view to improving the proposed programme budget for 1998-1999 and to facilitate its discussion at the Health Assembly.

12. Let me first recall the characteristics of the WHO strategic programme budget:

- the **proposed programme budget** is first considered by the Executive Board, thus giving flexibility to the process and allowing adjustments to be made as a result of the Board's comments;
- the **cost increases** are presented separately and introduced later both to allow a comparison with the preceding programme budget, and to ensure that they are as up to date as possible;
- resources are shifted towards **priorities** identified by Member States and governing bodies;
- strategic orientation and **quantified targets** facilitate specific evaluation at a later stage;
- the tasks of WHO are expressed in terms of **products**; details of the activities that lead to these products are contained in the **plans of action** which are prepared as close as possible to programme implementation;
- products are presented according to the **location of the activities** which will lead to their realization, i.e. at country, regional or global levels.

13. The Executive Board, in resolution EB99.R15, recommended that the Health Assembly should adopt a resolution with a view to ensuring a close link between the health-for-all policy for the twenty-first century, the Tenth General Programme of Work (as the framework for WHO's activities to implement the policy), the related programme budgets (as the tools for implementation of the Tenth General Programme of Work) and evaluation (to ensure that WHO's activities are relevant to and effective for implementation by Member States of the health-for-all policy). Pending the Health Assembly's decision, I am already establishing the necessary measures that would allow the Organization to respond to this resolution. I shall be particularly careful to ensure that the WHO targets are consistent with the targets of the new policy, and that this policy shapes the work of the Organization.

14. In resolution EB99.R13 the Executive Board requested me to complete WHO's strategic budgeting process through a series of managerial and financial measures. Considering the complexity of these requests and the time needed to prepare some of them, the Board gave me the choice between implementing these recommendations in the 1998-1999 programme budget or in subsequent programme budgets.

15. I have decided to implement the maximum number of these recommendations for the 1998-1999 biennium in order to avoid any delay in **pursuing reforms** in WHO, and I describe below the process and changes used to comply with these recommendations.

16. In addition, the Board commented specifically on the programme content of the six chapters of the proposed programme budget (see paragraph 9 above). Related modifications in the text of the proposed programme budget will be introduced in the final version of the programme budget for 1998-1999, together with any changes indicated by the Health Assembly.

## II.1 Strategic objectives and measurable targets (resolution EB99.R13, paragraphs 2.A.(1) and (2))

17. In the proposed programme budget for 1998-1999 an attempt has been made for the first time to define WHO targets, quantified wherever possible, that set out specific goals for the Organization and act as a yardstick to measure the efficiency and effectiveness of programmes. Operative paragraphs 2.A.(1) and 2.A.(2) requested us to add **strategic objectives** for all programmes and to clarify targets wherever feasible. I therefore list below the objectives that will be inserted immediately before WHO targets in the final version of the programme budget. A number of quantified targets for the period 1998-1999 have also been drawn up, but have not been included below for the sake of brevity. They are available from the programmes themselves and will be included in the final version of the programme budget to be issued after approval by the Health Assembly and in the respective plans of action for 1998 and 1999. Needless to say, these objectives and targets will be further refined in the proposed programme budget for 2000-2001.

| PROGRAMME | *Page, document PB/98-99* | OBJECTIVES |
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| **1. GOVERNING BODIES** | | |
| **1.1 Governing bodies** | *14* | To determine the policies of the Organization (World Health Assembly); to give effect to the decisions and policies of the Health Assembly (Executive Board); to formulate policies governing matters of an exclusively regional character (regional committees). |
| **2. HEALTH POLICY AND MANAGEMENT** | | |
| **2.1 General programme development and management** | | |
| • Executive management, Legal services, Director-General and Regional Directors' Development Programme, and Internal Audit and Oversight | *24* | To plan and manage the Organization's activities; to ensure observance of applicable policies and rules and to protect WHO's legal interests. To examine and appraise the way in which activities are carried out at all organizational levels, by means of internal audits, investigations, inspections and other oversight techniques. |
| • Managerial process for WHO programme development, including staff and management development | *25* | To promote and support the efficient and effective development and management of the Organization's policy and programmes, including long-, medium- and short-term planning, implementation, monitoring and evaluation for the benefit of Member States. To strengthen staff skills through briefing and training. |

| PROGRAMME | *Page, document PB/98-99* | OBJECTIVES |
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| • Management of and support to the information system | *27* | To facilitate the efficient and effective work of the Organization's programmes; to develop and maintain a modern computing and communications environment that will provide WHO's managers, staff, Member States, collaborators and public with easy access to needed information and with improved communication by:<br>- developing and implementing information systems, such as the WHO worldwide management information system;<br>- providing and developing information technology tools, services and support so that WHO's programmes and staff can fully benefit from their potential;<br>- establishing and maintaining the networking infrastructures for WHO offices and for the global WHO communications network, thus enabling the Organization to function more rapidly, effectively and cohesively; and<br>- ensuring coordination of WHO's policy and standards on the above. |
| • External coordination and resource mobilization for health | *28* | To serve as the focal point for ensuring coordination of the Organization's activities with external partners; to maintain high-level contacts with Member States, organizations and bodies of the United Nations system and other partners to ensure relevance of action; to mobilize financial and intellectual resources for the implementation of the Organization's programme. |
| **2.2 Health, science and public policy** | | |
| • Health policy in development | *34* | To ensure the centrality of health in the development process, and to protect and promote health in development policies and economic strategies. |
| • Women's health and development | *36* | To advocate for women's right to health security throughout their life span, taking into account both biological and gender factors affecting women's health and well-being; to improve the health status of girls and women through access to quality health care and relevant services. |
| • Human rights and health | *37* | To safeguard and promote all health-related human rights in health care; to foster recognition and awareness of the right to health security, particularly of vulnerable groups and populations. |
| • Research policy and strategy coordination | *38* | To promote research policies and strategies supportive of the goals of health for all; to coordinate the undertaking of relevant scientific activities in accordance with resolution WHA43.19. |
| • Health legislation; ethical dimensions of health care, and bioethics | *39* | To support and foster national efforts to formulate and implement health legislation that is in harmony with, and supportive of, national strategies for health for all. |

| PROGRAMME | *Page, document PB/98-99* | OBJECTIVES |
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| **2.3 National health policies and programmes development and management** | | |
| • Technical cooperation with countries | | To enhance and maintain the capability and capacity of WHO to provide technical contributions to the countries in order to strengthen national capability for policy and programme development, management and evaluation. |
| • Strategic support to countries and peoples in greatest need | *42* | To strengthen national health systems and to promote health development, thereby contributing to attainment of health for all through primary health care in countries in greatest need, by building up national capabilities in analysis and assessment of key constraints to health development; proposing policies and strategies for health development within the context of countries' overall socioeconomic development; promoting active participation of all major health-related stakeholders; facilitating coordination of all efforts and cooperating in mobilization of all national and international resources. |
| • Emergency and humanitarian action | *43* | To strengthen Member States' capacity to prepare for emergencies and to reduce adverse consequences of natural and man-made disasters; to respond to emergency situations and collaborate with national authorities in rebuilding their health systems; to promote policies and programmes for safety promotion and injury control, including public health aspects of violence. |
| • Supply services | *46* | To provide, at the lowest possible cost, appropriate equipment and supplies, and to ensure their timely delivery. |
| **2.4 Biomedical and health information and trends** | | |
| • Global health situation analysis and projection | *51* | To analyse the global and regional health situation and trends and make projections; to monitor and evaluate implementation of the Global Strategy for Health for All; to disseminate statistical and epidemiological information. |
| • Strengthening country health information | *52* | To strengthen country health information through design, testing and transfer of practical methods for assessing and developing national information systems in support of public health functions. |
| • Partnerships and coordination in epidemiology, statistics and trend assessment | *53* | To coordinate activities in epidemiology, statistics and trend assessment with related programmes and relevant offices of other international organizations; to support development and maintenance of standard statistical tools. |
| • World health reporting | *54* | To make an annual assessment of the global health situation and trends and of WHO's contributions to world health, and to outline priorities for international health action (charting the future); to prepare and publish annually *The world health report*, focusing on a priority health issue, and to promote its use by the international community. |

| PROGRAMME | | OBJECTIVES |
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| • Publications and documents | *54* | To support Member States by publishing, disseminating and providing access to up-to-date, validated health information and appropriate learning and reference material on priority subjects originating in WHO programmes in as many official and other languages as possible; to foster development in countries of capability to publish and disseminate health information. |
| • Library services | *55* | To provide comprehensive library and information services to WHO headquarters, regional and country offices, ministries of health and other government offices, health workers in Member States, other organizations and bodies of the United Nations system, international organizations and diplomatic missions, on WHO-produced information in print and other media and on worldwide health, medically-related and development information resources; to collaborate with regions and developing countries so that they achieve self-sufficiency in provision of information services to the health sector. |
| **3. HEALTH SERVICES DEVELOPMENT** | | |
| **3.1 Organization and management of health systems based on primary health care** | | |
| • Health systems research and development | *62* | To promote the concept and practice of health systems research, to support strengthening of countries' institutional and human resources capacity for using health systems research as an essential problem-solving and decision-making tool at all levels of the health system, and to organize these efforts into a sustainable process. |
| • National health systems and policies | *64* | To promote and support the organization and operation of equitable and sustainable health systems, and to analyse and disseminate lessons from countries' experience in the health development and reform process. |
| • District health systems | *65* | To cooperate with countries to strengthen and consolidate their district health systems, within the overall context of national health systems, in order to ensure that they deliver comprehensive, integrated health care effectively, in accordance with the primary health care approach. |
| **3.2 Human resources for health** | *72* | To cooperate with countries so that they reach the right number and the right mix of health professionals, working at the right locations, to respond to their health policy objectives. |

| PROGRAMME | | OBJECTIVES |
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| | *Page, document PB/98-99* | |
| **3.3 Essential drugs** | *78* | To increase the capability of countries to formulate and/or update national drug policies, implement them in the most cost-effective ways, and monitor them on a regular basis; to ensure the regular availability of essential drugs of acceptable quality at affordable costs; to increase the capacity of countries to ensure that drugs made available to the population are safe, effective, of acceptable quality and accompanied by appropriate information; to improve the use of drugs by prescribers, dispensers and the general public in order to maximize the potential contribution of pharmaceuticals to preventive and curative health care and to ensure the allocation of resources based on cost-benefit analysis. |
| **3.4 Quality of care and health technology** | | |
| • Blood safety | *84* | To cooperate with Member States in developing and strengthening mechanisms to promote the provision of safe blood and blood products. |
| • Quality assurance and health technology assessment | *85* | To advocate the importance of technology assessment and quality assurance in expanding and improving health services, especially at the primary health care level. |
| • Clinical technology and related services | *86* | To support countries in improving the quality of health care, particularly at district level. |
| • Health laboratory technology | *87* | To develop and promote scientifically and ethically sound and cost-effective laboratory technology aimed at improving quality and equity of access especially to primary health care. |
| • Radiation medicine and technology | *88* | To support countries in increasing access to diagnostic and therapeutic radiological services while maintaining their quality and safety. |
| • Drugs and biologicals, quality, safety and efficacy | *89* | To develop, harmonize and promote national and international standards, thereby providing all Member States with means for monitoring and maintaining quality, safety, efficacy and rational use of pharmaceutical and biological products. |
| • Traditional medicine | *91* | To collaborate with Member States in improving use of traditional medicines, particularly in primary health care. |
| **4. PROMOTION AND PROTECTION OF HEALTH** | | |
| **4.1 Reproductive, family and community health and population issues** | | |
| • Reproductive health technical support **and** | *101* | To strengthen the capability of countries to enable people to promote and protect their own health and that of their partners as it relates to sexuality and reproduction, and to have access to and receive quality health services when needed. |
| • Special Programme of Research, Development and Research Training in Human Reproduction | *102* | |
| • Adolescent health and development | *104* | To promote the health and development of young people through support for the formulation and implementation of effective policies and programmes. |

| PROGRAMME | | OBJECTIVES |
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| | *Page, document PB/98-99* | |
| • Women's health | *105* | To promote and protect women's health and well-being. |
| • Occupational health | *106* | To protect and promote the health of the working population, and to encourage humanization of work. |
| • Ageing and health | *107* | To promote health and well-being throughout the entire life span, and to collaborate with Member States in ensuring the availability and provision of comprehensive and holistic health care to older populations. |
| **4.2 Healthy behaviour and mental health** | | |
| • Health education and health promotion | *113* | To enable people to increase control over and to improve their health through advocacy for health-supportive public policies and national capacity-building, empowerment with the knowledge, values and skills to live healthy lives, and alliance-building to create supportive conditions. |
| • Health communications and public relations | *114* | To support countries in developing an informed public opinion among all peoples on matters of health by making greater use of all modern communication techniques to introduce health promotion and disease prevention concepts and to create an understanding of the relation between health and human development; establishing partnerships in health communications with the mass media, nongovernmental organizations, WHO collaborating centres etc., to create an increased awareness of health problems, and make WHO activities and programmes better known; and creating a network for the fast delivery of health information in emergency situations. |
| • Mental health | *115* | To promote service structures, legislative provisions, treatment and preventive strategies that can reduce the burden of mental and neurological disorders in the world; to ensure that attention is paid to psychosocial development and mental well-being, within all health programmes, by providing advice and support for psychosocial interventions and evaluations, and by encouraging activities in other sectors with this objective. |
| • Substance abuse | *116* | To promote health for all by preventing and reducing the adverse consequences of alcohol, tobacco and other psychoactive substance use by improving national and global policies and programmes; strengthening service provision and human resources development; collecting, consolidating and disseminating information; and promoting strong collaborative partnerships. |
| • Rehabilitation | *118* | To promote and enhance the integration of rehabilitation into health policies; to strengthen rehabilitation services through development of specific tools and methodologies for building capability of health services personnel; to promote strategies to improve living conditions and equalization of opportunities for all persons with disabilities. |

| PROGRAMME | | OBJECTIVES |
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| | *Page, document PB/98-99* | |
| **4.3 Nutrition, food security and safety** | | |
| • Nutrition | *122* | To promote, strengthen and support national capabilities for assessing nutrient- and diet-related problems and their main causes and contributing factors; developing strategies for dealing with malnutrition, whether of deficiency or excess, that are compatible with prevailing socioeconomic conditions; and applying these strategies and evaluating their effectiveness for the purpose of preventing, detecting and managing malnutrition. |
| • Food safety | *124* | To support national food safety programmes on infrastructure development, awareness promotion, and information development and transfer, with a view to protecting human health against hazards associated with biological and chemical contaminants and additives in food. |
| • Food aid | *126* | To provide technical guidance on health-related issues at all stages of design and evaluation of the WFP's programmes and projects; to ensure promotion and protection of the health of direct and indirect beneficiaries of WFP's developmental food-assisted projects; to encourage the active participation of national health authorities in food-aid supported development projects. |
| **4.4 Environmental health** | | |
| • Community water supply and sanitation | *132* | To promote human health through support to measures by Member States for the provision and management of safe and adequate community water supply and sanitation. |
| • Environmental health in urban development | *134* | To encourage and support countries and municipalities in their efforts to manage and deal effectively, and in a sustainable way, with factors affecting the urban environment (e.g. pollution) and therefore urban health. |
| • Assessment of environmental health hazards | *134* | To strengthen and promote research and generation and dissemination of information on environmental health hazards; to foster integrated health and environment planning; to increase national capability, particularly through education and training. |
| • Promotion of chemical safety | *135* | To protect human health and the environment from the adverse effects of chemical hazards. |
| • Incorporation of health concerns into environmental management | *139* | To promote the incorporation of health concerns into environmental management within the context of sustainable development; to foster intersectoral action for health and environment. |

| PROGRAMME | | OBJECTIVES |
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| | *Page, document PB/98-99* | |
| **5. INTEGRATED CONTROL OF DISEASE** | | |
| **5.1 Eradication/elimination of specific communicable diseases** | | |
| • Dracunculiasis | *146* | To interrupt transmission of dracunculiasis by 2000 in all but one country, and to eradicate the disease shortly thereafter. |
| • Leprosy | *147* | To eliminate leprosy globally by 2000 (e.g. a prevalence of less than one case per 10 000 population in all countries). |
| • Poliomyelitis | *148* | To eradicate poliomyelitis globally by 2000 (e.g. the cessation of person-to-person transmission of the causative agent). |
| • Neonatal tetanus | *149* | To eliminate neonatal tetanus globally by 2000 (an incidence of less than one case per 1000 live births in all districts). |
| **5.2 Control of other communicable diseases** | | |
| • Vaccines and immunization | *160* | To eradicate, eliminate or control vaccine-preventable diseases, giving primacy to diseases of public health priority, especially in developing countries, for which cost-effective vaccines are available. |
| • Child health and development | *161* | To reduce child mortality from the major life-threatening diseases of childhood and to promote the healthy growth and development of children under five years of age. |
| • Tuberculosis | *163* | To reduce the incidence of tuberculosis below the level considered to be a public health priority (less than 10 cases per 100 000 population in developing countries; less than one case per million population in industrialized countries). |
| • Surveillance and control of emerging and other communicable diseases | *165* | To strengthen national and international capacity in recognition, surveillance, prevention and control of communicable diseases, including those that represent new, emerging and re-emerging public health problems, including antimicrobial resistance, by promoting development of national and international infrastructure and resources, and research and training, including on diagnosis and epidemiology. |
| • HIV/AIDS and sexually transmitted diseases | *166* | To survey epidemiological evolution and trends of HIV/AIDS and sexually transmitted diseases; to prevent, detect and treat sexually transmitted diseases; to prevent sexual, blood-related and perinatal transmission of HIV; to reduce transmission associated with substance use; to improve care and support for persons or groups affected by HIV/AIDS by strengthening health care systems so that they promote adequate and appropriate societal responses to HIV/AIDS. |

| PROGRAMME | | OBJECTIVES |
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| | *Page, document PB/98-99* | |
| • Control of tropical diseases | *167* | To eradicate, eliminate or control selected parasitic diseases prevalent in tropical climates, including those caused by protozoa (leishmania, trypanosomes, plasmodia) and helminths (schistosomes, filaria and intestinal parasites). |
| • Research and training in tropical diseases | *168* | To strengthen research and research capability to provide new and improved tools for the diagnosis, treatment and prevention of tropical diseases. |
| • Prevention and control of blindness and deafness | *170* | To prevent blindness and deafness as public health problems (the prevalence of blindness to be less than five per 1000 population in all countries, less than 10 per 1000 in all communities; corresponding rates have not yet been established for deafness). |
| **5.3 Control of noncommunicable diseases** | | |
| • Integrated prevention and control of noncommunicable diseases | *176* | To ensure that all Member States are provided with information on the strategy of integrated prevention and control of noncommunicable diseases, which could be adapted according to national priorities within the framework of health sector reform. |
| • Cardiovascular diseases | *177* | To elaborate and test user-friendly programme modules in support of interventions to monitor, prevent and manage cardiovascular diseases and their risk factors. |
| • Cancer, including IARC | *178* | To research, disseminate and promote further knowledge on critical issues of cancer prevention and control, including updated information on optimal procedures in management and care of cancer patients. |
| • Diabetes mellitus | *179* | To ensure the necessary support to Member States in assessing the burden of diabetes mellitus, and in advising on cost-effective approaches to its prevention and management. |
| • Chronic nonspecific pulmonary and rheumatic diseases | *180* | To increase awareness of public health consequences of chronic nonspecific pulmonary and chronic rheumatic diseases, and to update knowledge on prevention and control measures. |
| • Oral health | *180* | To reinforce the global communication network and to support Member States in introducing affordable community preventive and oral care programmes. |
| • Hereditary diseases | *181* | To increase public awareness of the prevalent hereditary disorders, and to support the development of adequate genetic counselling services. |

| PROGRAMME | | OBJECTIVES |
|---|---|---|
| | *Page, document PB/98-99* | |
| **6. ADMINISTRATIVE SERVICES** | | |
| **6.1 Personnel** | *186* | To manage and develop the Organization's human resources in an optimal way in order to support implementation of technical programmes, enhancing efficiency and responsiveness to the needs of Member States. |
| **6.2 General administration** | | |
| • Provision of building and office services | *189* | To manage and provide timely and effective logistic support for implementation of WHO's programmes and activities in respect of building and office services. |
| • Provision of communications, records management, conference and security services | *189* | To manage and provide timely and effective logistic support for implementation of WHO's programmes and activities in respect of communications, records, conference and security services. |
| • Planning, management and control of administrative activities | *190* | To provide effective direction and control of the Organization's general administrative activities in support of the programmes, including policy formulation, resources planning and allocation. |
| **6.3 Budget and finance** | | |
| • Provision of computer-based administration and finance information systems | *192* | To provide and support computerized administration and finance systems at headquarters and in the regional offices. |
| • Budget policy, preparation, control and monitoring | *193* | To provide effective, efficient and flexible budgetary support and services at all organizational levels, under all sources of funds. |
| • Management, control and monitoring of financial operations | *193* | To provide effective, efficient and flexible financial and accounting support and services at all organizational levels, under all sources of funds. |

## II.2 Resources allocated to priorities (resolution EB99.R13, paragraphs 2.A.(5), 2.B.(1) and 2.B.(2)(b))

18. Under my chairmanship, the Global Policy Council, which met immediately after the Board, considered ways better to reflect, at all levels, the priorities recommended by the Executive Board. Having reviewed the options, I have decided to put forward the proposals contained in the following paragraphs.

19. At **headquarters** I decided to maintain for 1998-1999, to the extent possible in view of the financial constraints imposed by the real budget cuts in 1996-1997, the substantial amounts shifted towards priorities in the 1996-1997 programme budget, before and after discussions at the Executive Board. My task was made easier because the special group of the Executive Board had decided, on 17 May 1996, to maintain the 1996-1997 priority areas for the 1998-1999 biennium. Thus, under the regular budget, distribution for the global and interregional level is as follows:

| | 1994-1995 US $ | 1996-1997 US $ | 1998-1999 (proposed) US $ |
|---|---|---|---|
| (a) | Eradication of specific communicable diseases | | |
| | 641 871 | 4 507 600 | 6 669 600[1] |
| (b) | Prevention and control of specific communicable diseases | | |
| | 30 558 789 | 33 525 100 | 37 802 400[1] |
| (c) | Reproductive health, women's health and family health | | |
| | - | 7 267 000 | 8 076 000 |
| (d) | Promotion of primary health care | | |
| | 6 724 295 | 8 121 300 | 7 743 100 |
| | Essential drugs and vaccines | | |
| | 1 481 304 | 3 018 700 | 3 037 900 |
| | Nutrition | | |
| | 6 239 049 | 7 164 000 | 6 664 600 |
| (e) | Promotion of environmental health - community water supply and sanitation | | |
| | - | 4 311 000 | 4 378 000 |

20. At **regional and country levels**, a number of Regional Directors indicated that they had difficulties in making substantial changes on the basis of the 1996-1997 budget, because of the real reductions that it represented and the shifts already made for 1994-1995. It was also emphasized that at country level it was still important to respond to national priorities whenever possible. There were also "natural" differences between the various regional and country budgets as presented in the 1998-1999 proposals considered by the Executive Board, which give a varying scope for revision. Nevertheless, the regions have made a considerable effort to respond to the Board's concerns, as outlined below.

- **African Region**

  - Major programmes 3.1 (Organization and management of health systems based on primary health care) and 4.1 (Reproductive, family and community health and population issues) are in line with Executive Board expectations. The decrease in programmes 3.3 (Essential drugs), 3.4 (Quality of care and health technology) and 4.4 (Environmental health) is at the country level. The Regional Office has therefore requested the WHO Representatives to re-examine the country budgets and advise on action during the final planning and implementation phases.

  - In regard to countries in greatest need, the intercountry portion of major programme 2.3 (National health policies and programmes development and management) has been reduced and a transfer made

[1] This figure includes part of the 2% shift from other headquarters programmes that will be spent at country level.

to a country budget. The total amount now proposed for the least developed countries is US$ 62 200 000, slightly more than in the previous programme budget.

- **Region of the Americas**

  - At country level specific programme 4.4.1 (Water supply and sanitation in human settlements) has been increased by US$ 567 000. Major programme 2.3 (National health policies and programmes development and management) has been increased by US$ 431 000, and programme 4.3 (Nutrition, food security and safety) by US$ 150 000. These increases have been offset mainly by decreases in fellowships and in programme 2.4 (Biomedical and health information and trends).

- **South-East Asia Region**

  - Priority major programmes 3.3 (Essential drugs), 4.3 (Nutrition, food security and safety), and 4.4 (Environmental health) have been increased by US$ 851 400. Major programme 3.1 (Organization and management of health systems based on primary health care) had already been increased by US$ 2.2 million, as compared to the approved budget for 1996-1997. The corresponding amount has been deducted from major programme 2.1 (General programme development and management) and from specific programmes 2.3.1 (Technical cooperation with countries) and 5.3.1 (Control of noncommunicable diseases).

  - Planning figures of the countries in greatest need have been increased by US$ 851 400. The corresponding amount has been deducted from other countries.

- **European Region**

  - Over the past two bienniums, 10% of total regular budget resources have been transferred to the priority programmes defined by the Executive Board. The Board's instructions have therefore been fully complied with, and no further shifts are needed.

  - In total, from 1994-1995 to 1996-1997 transfers to priorities represented 5.8% of the total regular budget, including increased allocations to countries in greatest need.

  - In the proposed programme budget for 1998-1999, US$ 2 268 000 (or 4.5%) has been transferred to the seven major programme areas which make up the five broad programme priorities defined by the Executive Board. The small decrease of US$ 132 400 in programme 3.3 (Essential drugs) should be seen in relation to expected generous funding from other sources.

  - Major programme 4.1 (Reproductive, family and community health and population issues) has been decreased by US$ 374 300 because the Regional Office has laid less emphasis on adolescent health and also temporarily allocated a lower priority to ageing and health. Further, activities related to occupational health will be implemented under major programme 4.4 (Environmental health), which has been increased substantially. Collectively, reproductive health, child health and women's health have been increased by US$ 281 000 as compared to the past biennium.

  - The increase of US$ 362 900 in programme 1.1 (Governing bodies) stems entirely from reclassification of staff costs. This was done in order to achieve greater transparency and to reflect budgetary provisions where actual expenditures are incurred, in line with the Health Assembly's successive resolutions on budgetary reform. Further, the Regional Director has made specific proposals on the possibility of reducing the frequency of regional committees to a biennial cycle, and on use of official languages in the Region. Significant, real savings would have accrued if these proposals had been

adopted by the governing bodies. However, to reclassify posts back to other programmes in order to present nominal zero growth would be contrary to the spirit of earlier resolutions on budgetary reform.

- **Eastern Mediterranean Region**

  - The amount of US$ 4 287 200 has been transferred to priority programme 3.1 (Organization and management of health systems based on primary health care), and US$ 410 000 to programme 3.3 (Essential drugs).

  - No transfer has been made to programmes 4.2 (Healthy behaviour and mental health) or 4.4 (Environmental health) since the proposed programme budget for 1998-1999 shows an increase in these two programmes over the 1996-1997 programme budget.

  - These shifts should help to alleviate the apparent decrease in funding for priority programmes in the proposed programme budget, while maintaining a balanced relationship between the activities of programmes whose funding has been reduced and those where it has been increased.

  - A substantial proportion of the funds raised from other sources is directed to the least developed countries. In addition, a large part of the intercountry and regional allocations are used to support them. For example, most of the Regional Director's Development Fund goes directly or indirectly to them.

- **Western Pacific Region**

  - Allocations to the Executive Board priorities represent 77.76% of the proposed programme budget. However, in response to the request by the Executive Board, a further US$ 269 000 has been transferred to programme 3.1 (Organization and management of health systems based on primary health care).

  - Funding for programmes 3.3 (Essential drugs) and 4.3 (Nutrition, food security and safety) have been increased in 1998-1999 as compared with 1996-1997; hence no further changes are proposed.

  - Savings of approximately US$ 1.7 million have been made in programme 4.4 (Environmental health) by a reorientation of activities. This was done as part of the restructuring of regional operations, without compromising technical support to countries. Further adjustments to this area are therefore not necessary.

  - It is proposed to make provision for an additional country-based post for environmental health issues in one least developed country, thus increasing the allocation for least developed countries by US$ 323 400. In addition, 20% of the funds under the Regional Director's Development Programme will be preallocated to control of emerging diseases, including cholera, other communicable diseases, and zoonoses, and to antimicrobial resistance. Every effort will be made to use this and part of the funds remaining in the Regional Director's Development Programme for disease control in least developed countries.

21. Turning now to the request of the Board to present as a **matrix**, the part of the budget dedicated to the different elements of **primary health care** (see paragraph 10 above), in addition to the increased funds for programme 3.1 (Organization and management of health systems based on primary health care), the result is given below. Figures are approximate to a certain extent, because of the nature of the definition of the primary health care elements in certain programmes.

## PRIMARY HEALTH CARE ELEMENTS AT REGIONAL AND GLOBAL/INTERREGIONAL LEVELS

US$ million at 1996-1997 cost level

| Primary health care elements | Africa | The Americas | South-East Asia | Europe | Eastern Mediter-ranean | Western Pacific | Global/ inter-regional | Total |
|---|---|---|---|---|---|---|---|---|
| 1. Education concerning prevailing health problems and the methods of preventing and controlling them | 2.81 | 1.62 | 2.76 | 1.20 | 1.58 | 3.36 | 5.92 | 19.25 |
| 2. Promotion of food supply and proper nutrition | 1.96 | 2.80 | 2.73 | 0.81 | 1.47 | 1.67 | 6.66 | 18.10 |
| 3. Adequate supply of safe water and basic sanitation | 6.78 | 5.97 | 4.18 | 1.20 | 4.32 | 3.75 | 6.52 | 32.72 |
| 4. Maternal and child health care, including family planning | 5.63 | 2.81 | 4.48 | 1.21 | 1.21 | 1.33 | 4.87 | 21.54 |
| 5. Immunization against the major infectious diseases | 2.63 | 2.40 | 3.06 | 0.73 | 3.36 | 2.43 | 12.29 | 26.90 |
| 6 and 7. Prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries | 16.15 | 14.09 | 14.27 | 2.20 | 9.16 | 11.16 | 34.33 | 101.36 |
| 8. Provision of essential drugs | 2.27 | 0.85 | 2.47 | 0.63 | 2.31 | 2.11 | 3.04 | 13.68 |
| **Total** | **38.23** | **30.54** | **33.95** | **7.98** | **23.41** | **25.81** | **73.63** | **233.55** |

### I.3 Other specific recommendations

22. As mentioned in paragraph 9 above, the Board, during its review of the six appropriation sections of the proposed programme budget for 1998-1999, specifically identified a number of other areas to which resources could be shifted or that should receive special attention.

23. Let me first explain how I intend to deal with specific programme 2.2.1 (Health in socioeconomic development) as related to **health policy in development**. After adoption by the Health Assembly, in May 1998, of the new policy for health for all for the twenty-first century, all programmes will reinforce their capacity to deal with health policy in development in their specific areas, as this is an expressed priority and principle of the new policy. In addition, I intend to request the Deputy Director-General a.i. to coordinate all elements of health policy within sustainable development. Lastly, I shall devote some funds from the Director-General's Development Programme to activities in this field whenever necessary. It is proposed to re-evaluate this *modus operandi* at the end of 1998 to see if it is the proper way of dealing with the matter.

24. With regard to the need to ensure better links with WHO collaborating centres supporting implementation of specific programme 4.1.7 (**Occupational health**), I have decided to increase the 1998-1999 budget of this programme by US$ 100 000 in response to the request of the Executive Board.

25. I was also asked to provide a text relating to **technical cooperation with countries**. This activity is primarily related to financing of the WHO offices at country level and other support to national health policy and management development. I therefore propose to add the text that follows under major programme 2.3 (National health policies and programme development and management).

***World situation and targets***

...

In most countries and areas, WHO country offices, whether fully-fledged offices of WHO Representatives or WHO liaison offices, provide the links between government and the regional offices and headquarters. As part of the decentralization process under way in WHO, a strong country presence will be crucial in the future. Work is therefore going ahead to strengthen further the role of country offices.

***Evaluation - main achievements and constraints***

...

- Technical capabilities of WHO at country level were strengthened in most regions through the expansion of technical staff recruited locally, and through regular technical and managerial training, especially in the African Region. All WHO offices are now equipped with computer facilities and most are linked to the regional office and headquarters through electronic communication.
- Special attention was given to providing support to countries for emergency preparedness and disaster relief. Collaboration with other partners, especially other organizations of the United Nations system, was strengthened through the mechanisms of the Resident Coordinator system, and WHO is an active partner in the preparation of the Country Strategy Note. WHO Representatives are the secretaries of UN Theme Groups on HIV/AIDS in more than 80% of countries. They also play an increasing role in advocacy and liaison with other organizations of the United Nations system, donors, and nongovernmental organizations in order to maximize the use of resources and to avoid duplication and overlap.
- Support was provided to countries for regular analysis of health needs in priority-setting, and updated country profiles are available in most regions.
- Essential WHO documents are now available in all WHO country offices through library facilities electronically linked with regions and headquarters.
- As advised by the Executive Board, the recommendations of the development team on the role of WHO country offices are now being implemented.

***Budgetary comments and trends***

...

African Region: a significant increase in funding is required in order to strengthen technical capability of WHO country offices by employing national professional officers in priority programmes. Training of WHO staff will also receive priority. The recently created emergency unit will be strengthened so as to be able to respond to country requests promptly and effectively.

Region of the Americas and South-East Asia Region: the budget has slightly decreased as considerable efforts have been made to increase operational efficiency.

European Region: the budgetary increase is required to strengthen the network of country information systems and to develop the clearing-house on essential vaccines and pharmaceuticals for newly independent States.

Eastern Mediterranean Region: increases in the proposed budget respond to emphasis laid by joint programme review missions on capacity-building in policy analysis and formulation, and on health management support.

Western Pacific Region: considerable effort has been made to streamline and increase operational efficiency. Ten posts (six professional and four support staff) have been frozen, but the budget remains at approximately the same level as in 1996-1997.

*Products and projections*

## TECHNICAL COOPERATION WITH COUNTRIES

Objective — To enhance and maintain the capability and capacity of WHO to provide technical contributions to the countries in order to strengthen national capability for policy and programme development, management and evaluation.

WHO targets — By 1999

- Evaluation mechanisms to assess the efficacy, effectiveness and impact of WHO country offices will have been established
- All WHO country offices will have been equipped to support governments in emergency preparedness and disaster relief and staff will have received appropriate training
- A new process for analysis of technical cooperation in health will have been established in the Region of the Americas
- At least 70% of Member States in the Eastern Mediterranean Region will have developed and strengthened their national managerial process, including plans to mobilize the necessary resources to support implementation of health-for-all policies and strategies

| 1998-1999 products | Projections for 2000-2003 |
|---|---|
| *Country level (type of product)* | |
| Increased awareness among partners in health and development of the importance of health and its inclusion in major discussions, forums, roundtables, etc. | To be continued |
| Strengthened support to countries for improving national capability in health policy formulation, health planning and management | Improved efficiency and effectiveness in developing, implementing and evaluating health programmes at country level |
| WHO country programmes monitored and reviewed | To be continued |
| Country programme profiles drawn up and regularly updated | Regular updating |
| Information, rapid assessment and standard assistance package for emergency preparedness and disaster relief | Monitor use of package |
| Donor assistance to the health sector coordinated through analysis and harmonization of current donor-assisted projects; new projects formulated | To be continued |
| Guidelines on organizational structures of ministries of health | Monitor use of guidelines |
| Tools for monitoring and evaluation of national health programmes | Monitor use of tools |
| National plans for mobilization of human and financial resources | Monitor application of plans |

| 1998-1999 products | Projections for 2000-2003 |
|---|---|
| ***Regional level (type of product)*** | |
| Electronic teamwork set up in the Region of the Americas for rapid dissemination of information to country offices | Continuation of activities to complete and to sustain products |
| Subregional initiatives promoted in the context of technical cooperation among countries | To be continued |
| Programme execution regularly monitored and assessed at country level | To be continued |
| Criteria for establishment of WHO country offices regularly monitored | Continue monitoring |
| Regular technical and management training courses for WHO country level staff | To be repeated as necessary |
| Fully operational emergency unit in the African Region | |
| Training institution on health policy and management established in the Eastern Mediterranean Region | Monitor functioning and use |
| ***Global level*** | |
| Recommendations of the development team on the role of WHO country offices implemented | Monitor implementation |

26. Concerning **administrative costs** included under appropriation section 6 of the proposed programme budget for 1998-1999, the requirements are heavily based on local currency in five regional offices and at headquarters. As such, and after incorporating cost increases and currency adjustments, a noticeable reduction appears in the regular budget, as a result of the stronger United States dollar (see Part IV of the present document). Extrabudgetary expenditures under section 6 are also expected to fall from US$ 68 million to US$ 65 million. Consequently, the overall cost of section 6 will decrease from 11.44%, as now shown in the proposed programme budget for 1998-1999 presented to the Board, to a figure close to 10.55%.

27. Lastly, an analysis of the country planning figures devoted to the **least developed countries** in the budget presented to the Executive Board had shown a decrease of close to US$ 1 million for all 48 of these countries, before the transfer of 2% of the global and interregional activities to priority programmes at country level, as requested by resolution WHA48.26. The changes that have been introduced (see paragraph 20 above) will reduce this decrease to US$ 0.4 million. In addition, I am proposing that the transfer of the 2% to programmes 5.1 (Eradication/elimination of specific communicable diseases) and 5.2 (Control of other communicable diseases) should also be devoted to least developed countries and to certain other countries in greatest need, which will make available a further US$ 6 million for these priority countries.

## II.4 Other measures taken to implement resolution EB99.R13

28. **Paragraph 2.A.(3).** The question of evaluation mechanisms was discussed at length by the Programme Development Committee of the Executive Board, which approved the plans proposed for further development of the evaluation system in WHO during the period 1997 and 1998. In the various approaches described, it was stated *inter alia* that an evaluation report on implementation of the previous programme budget would be presented to the Health Assembly every other year, together with the financial report. Guidelines to this effect will be produced for review by the Executive Board at its 101st session in January 1998.

29. **Paragraph 2.A.(4).** The need to analyse nonfinancial constraints in the achievement of objectives, outcomes and delivery of products has been recognized, and this principle has already been introduced in the two strategic programme budgets (1996-1997 and 1998-1999) in the section entitled "Evaluation - main achievements and constraints". However, it is recognized that the analysis of constraints needs to be strengthened, and this will be emphasized in the guidelines for preparation of the proposed programme budget for 2000-2001.

30. **Paragraph 2.A.(6).** At the planning stage, joint government/WHO mechanisms select activities for collaboration with WHO according to countries' priority health needs, within the context of the general programmes of work, WHO's role and mission, and the national programmes. This mechanism ensures that full account is taken of health activities and programmes under way at country level when joint activities with WHO are both programmed and implemented.

31. **Paragraph 2.A.(7).** The presentation of the financial statements and the proposed programme budget does at present permit a comparison, primarily through the financial statements, of budgetary allocations with expenditure at the level of specific programmes. Further work will be done to refine this presentation.

32. **Paragraph 2.B.(2)(a).** The 2% transfer from global and interregional activities to priority programmes at country level amounted to US$ 5.97 million. This amount was primarily taken from programmes 2.2 (Health, science and public policy), 2.3 (National health policies and programmes development and management), 4.2 (Healthy behaviour and mental health), and 6 (Administrative services). As endorsed by the Board at its ninety-seventh session, US$ 3 million will be used in country programmes for incorporating HIV/AIDS activities into the mainstream of WHO programmes and, in countries of greatest need, US$ 2.97 million will be devoted to diseases that can be eliminated or eradicated. The countries concerned will be identified in the second half of 1997 after consultations, and the focus for all funding will be on countries in greatest need.

33. **Paragraph 2.B.(2)(c).** We are considering in detail a revised method of presentation of administrative costs associated with programme delivery with respect to projections for the programme budget for 2000-2001. For the proposed programme budget for 1998-1999, a breakdown showing administrative support costs prorated to technical programmes was given in document EB99/INF.DOC./8. It was based on a study made in 1994 indicating that 81% of total administrative support costs in appropriation section 6 were related to serving of technical programmes at all levels of the Organization. Copies of this document will be available during the Health Assembly debate.

34. **Paragraphs 2.B.(3) and 2.B.(4).** A first approach to development of an analytical framework to expedite setting and revision of priorities based on WHO's mandate, global health determinants and challenges, and a specific process for drawing up priorities for the Organization as a whole, will be presented to the Executive Board at its 101st session in January 1998. This first approach will be closely linked to adoption of the health-for-all policy for the twenty-first century and to preparation of the Tenth General Programme of Work and the proposed programme budget for 2000-2001.

35. **Paragraphs 2.C.(1) and 2.C.(2).** These paragraphs request me to propose a systematic policy for savings stemming from improved efficiency and to seek a savings target for 1998-1999 that could contribute to

reallocations for higher priority programmes and/or cost containment. The issue of efficiency savings has, of course, been a constant preoccupation of all offices and programmes for many years now. In the light of the Board's specific request, however, a renewed and consolidated effort is under way to evaluate past successes and to devise a more integrated approach for future measures. I shall report on progress to forthcoming sessions of the Board.

36. **Paragraph 2.D.(1).** In addition to better coordination emanating from the preparatory and follow-up work related to major United Nations conferences in the past few years (United Nations Conference on Environment and Development, 1992, International Conference on Nutrition, 1992, International Conference on Population and Development, 1994, World Summit for Social Development, 1995, Fourth World Conference on Women, 1995), preparation of the health-for-all policy for the twenty-first century has led to direct consultation with other organizations of the United Nations systems, multilateral institutions and nongovernmental organizations, in order to determine better the roles and functions of all these bodies in the implementation of health policies. The different administrations are already exploring greater use of common services and premises whenever programmatically and financially justifiable.

37. **Paragraph 2.D.(2).** A range of additional mechanisms to generate financial support for WHO initiatives and to implement WHO programmes more efficiently through partnerships are already being explored. These include direct financial cooperation, support in kind, staff secondments, logistic support and provision of drugs or technology. Longstanding partnerships exist, for example in poliomyelitis eradication and onchocerciasis control. New alliances are being forged for school health and blindness prevention, which include nongovernmental organizations, trade associations, professional associations and other organizations of the United Nations system. Many WHO collaborating centres contribute significant amounts of staff time, travel costs and other means of support to WHO programmes, and some have joined together to form highly effective networks, for example in occupational health. Many joint projects already exist with partners in the United Nations system. Increasingly, we are seeing tripartite projects between organizations of the United Nations system, nongovernmental organizations, and the private sector. WHO has been more restrained, despite the strong interest of the private sector to contribute to global health. Apart from longstanding partners in the health field, we are witnessing great interest from the media, the sports, travel and leisure industries, as well as many "lifestyle" companies. These potential partners could open new communication and dissemination channels across the globe, but clearer rules for cooperation still have to be established in order to be able to use their potential. It is becoming increasingly clear that outside partners are seeking involvement - they are more and more reluctant just to "sign a cheque" and provide financial support or sponsorship only. In many cases they have recognized the added value of health to their own work and want to be part of the larger WHO effort. As part of the renewal of the health-for-all policy, new mechanisms will have to be explored and studied by the governing bodies.

## II.5 Priorities in the programme budget for 2000-2001

38. In conclusion, I would like to reiterate the importance for WHO of continuing to ensure that allocation of resources are directed towards major priorities identified by the Board and Member States. Furthermore, and as identified by resolution EB99.R13, it is important to develop an analytical framework for the setting and revision of priorities based on WHO's mandate and on global health determinants and challenges. This subject is on the agenda of the 101st session of the Executive Board in January 1998 for initial discussion, and I expect that it will be included in future Board meetings as a permanent process. The complexity of setting priorities in WHO, with differing priorities at country level and in the six regions, and the need for globally established priorities had already been recognized by the Programme Development Committee of the Executive Board at its meeting last January (in discussing document EBPDC3/7 on "Priority-setting in WHO"). During this discussion, it became evident that a complete review of the present system was necessary, with a view to making more transparent the setting of the Organization's priorities at country, regional and global levels, and to define better the respective roles of the regional committees, the Executive Board and the Health Assembly.

39. Moreover, priorities have to be selected early enough in the process of programme budgeting. Preparation of the WHO programme budget starts with joint discussions between the Organization and governments beginning in December of the year of adoption of the previous programme budget. For example, they will start in December 1997 for preparation of the proposed programme budget for 2000-2001. Thus global priorities need to be determined early to ensure that they are communicated to countries in time for preparation of the next programme budget.

40. More generally, I welcome the closer dialogue on WHO's managerial process that has been instituted during the past four years between the governing bodies and the Secretariat, not only on priorities but on all other aspects. While I appreciate the complimentary comments of the Executive Board on WHO's approach to strategic programme budgeting, I recognize that for the period 2000-2001, we will need:

- to improve objectives and targets for programmes of the Organization;
- to define more sharply the Organization's products;
- to ensure more direct links between definition of these products and elaboration of the plans of action;
- to improve programme evaluation through systematic assessment of implementation of the programme budget, and definition and monitoring of programme indicators.

41. Although WHO's managerial process will continue to evolve, I consider that adoption of the proposed programme budget for 1998-1999 will be an important step towards improving programme management and another key reform in the Organization's budgeting processes.

# PART III

## REVISED BUDGETARY INFORMATION, TAKING INTO ACCOUNT THE RECOMMENDATIONS OF THE EXECUTIVE BOARD AND THE DIRECTOR-GENERAL'S RESPONSE

42. The following table shows the overall impact of the revisions to the 1998-1999 regular budget which the Director-General is now proposing. These revisions are at the 1996-1997 level of costs and exchange rates in order to enable programme changes to be clearly identified. Part IV gives the latest information on costs and exchange rates, together with their impact on the overall budget level for 1998-1999.

# PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1998-1999
# "REAL" CHANGES, BY MAJOR PROGRAMME
# (US dollars)

| | | Regular budget | | | |
|---|---|---|---|---|---|
| | | 1996-1997 | Programme changes presented at Executive Board ninety-ninth session | Further net shifts before Fiftieth World Health Assembly | 1998-1999 |
| **1.1** | **Governing bodies** | | | | |
| | Africa | 1 525 700 | (59 200) | | 1 466 500 |
| | The Americas | 337 100 | | | 337 100 |
| | South-East Asia | 312 500 | | | 312 500 |
| | Europe | 441 800 | 362 900 | | 804 700 |
| | Eastern Mediterranean | 231 200 | (1 200) | | 230 000 |
| | Western Pacific | 399 500 | 100 500 | | 500 000 |
| | Global and interregional | 16 209 300 | | (316 200) | 15 893 100 |
| | **Total** | **19 457 100** | **403 000** | **(316 200)** | **19 543 900** |
| | **Total: Appropriation section 1** | **19 457 100** | **403 000** | **(316 200)** | **19 543 900** |
| **2.1** | **General programme development and management** | | | | |
| | Africa | 15 148 700 | (6 356 300) | | 8 792 400 |
| | The Americas | 1 752 500 | 620 600 | | 2 373 100 |
| | South-East Asia | 3 601 100 | 837 000 | (5 000) | 4 433 100 |
| | Europe | 8 385 600 | (2 131 900) | | 6 253 700 |
| | Eastern Mediterranean | 7 820 200 | (531 500) | (900 000) | 6 388 700 |
| | Western Pacific | 4 867 100 | 1 295 700 | | 6 162 800 |
| | Global and interregional | 36 154 400 | (5 300) | 316 200 | 36 465 300 |
| | **Total** | **77 729 600** | **(6 271 700)** | **(588 800)** | **70 869 100** |
| **2.2** | **Health, science and public policy** | | | | |
| | Africa | 2 327 700 | (514 600) | | 1 813 100 |
| | The Americas | 2 170 300 | (670 900) | | 1 499 400 |
| | South-East Asia | 6 206 000 | (2 933 900) | | 3 272 100 |
| | Europe | 1 179 300 | 224 300 | | 1 403 600 |
| | Eastern Mediterranean | 484 200 | 1 542 500 | (488 600) | 1 538 100 |
| | Western Pacific | 1 865 900 | (401 800) | | 1 464 100 |
| | Global and interregional | 5 210 000 | (1 365 600) | | 3 844 400 |
| | **Total** | **19 443 400** | **(4 120 000)** | **(488 600)** | **14 834 800** |

| | Regular budget | | | |
|---|---|---|---|---|
| | 1996-1997 | Programme changes presented at Executive Board ninety-ninth session | Further net shifts before Fiftieth World Health Assembly | 1998-1999 |
| **2.3 National health policies and programmes development and management** | | | | |
| Africa | 32 304 100 | 6 294 800 | | 38 598 900 |
| The Americas | 6 838 300 | (640 900) | | 6 197 400 |
| South-East Asia | 16 381 100 | 490 200 | (541 300) | 16 330 000 |
| Europe | 4 162 100 | 569 000 | | 4 731 100 |
| Eastern Mediterranean | 10 448 500 | 1 815 100 | (1 517 600) | 10 746 000 |
| Western Pacific | 11 142 000 | (869 500) | (269 000) | 10 003 500 |
| Global and interregional | 14 324 300 | (1 631 100) | | 12 693 200 |
| **Total** | **95 600 400** | **6 027 600** | **(2 327 900)** | **99 300 100** |
| **2.4 Biomedical and health information and trends** | | | | |
| Africa | 7 226 400 | 855 800 | | 8 082 200 |
| The Americas | 8 215 900 | 2 219 400 | (639 200) | 9 796 100 |
| South-East Asia | 3 832 400 | (739 600) | | 3 092 800 |
| Europe | 6 936 100 | 595 200 | | 7 531 300 |
| Eastern Mediterranean | 4 979 400 | 1 082 100 | (151 000) | 5 910 500 |
| Western Pacific | 1 905 600 | 801 600 | | 2 707 200 |
| Global and interregional | 33 185 800 | (410 200) | | 32 775 600 |
| **Total** | **66 281 600** | **4 404 300** | **(790 200)** | **69 895 700** |
| **Total: Appropriation section 2** | **259 055 000** | **40 200** | **(4 195 500)** | **254 899 700** |
| **3.1 Organization and management of health systems based on primary health care** | | | | |
| Africa | 11 327 800 | 846 000 | | 12 173 800 |
| The Americas | 16 694 600 | (1 547 200) | 431 500 | 15 578 900 |
| South-East Asia | 8 356 700 | 2 169 300 | | 10 526 000 |
| Europe | 2 669 300 | 555 100 | | 3 224 400 |
| Eastern Mediterranean | 17 935 500 | (5 607 800) | 4 287 200 | 16 614 900 |
| Western Pacific | 9 618 000 | (314 700) | 269 000 | 9 572 300 |
| Global and interregional | 8 121 300 | (378 200) | | 7 743 100 |
| **Total** | **74 723 200** | **(4 277 500)** | **4 987 700** | **75 433 400** |

| | | Regular budget | | | |
|---|---|---|---|---|---|
| | | 1996-1997 | Programme changes presented at Executive Board ninety-ninth session | Further net shifts before Fiftieth World Health Assembly | 1998-1999 |
| **3.2** | **Human resources for health** | | | | |
| | Africa | 21 216 700 | (2 280 100) | | 18 936 600 |
| | The Americas | 2 999 600 | 2 095 200 | (510 000) | 4 584 800 |
| | South-East Asia | 9 806 700 | 81 700 | | 9 888 400 |
| | Europe | 1 819 400 | (121 900) | | 1 697 500 |
| | Eastern Mediterranean | 8 636 700 | 472 800 | (1 100 000) | 8 009 500 |
| | Western Pacific | 9 010 500 | (1 157 500) | | 7 853 000 |
| | Global and interregional | 4 879 700 | (214 200) | | 4 665 500 |
| | **Total** | **58 369 300** | **(1 124 000)** | **(1 610 000)** | **55 635 300** |
| **3.3** | **Essential drugs** | | | | |
| | Africa | 2 863 800 | (591 800) | | 2 272 000 |
| | The Americas | 716 900 | 136 900 | | 853 800 |
| | South-East Asia | 2 446 300 | (365 000) | 390 100 | 2 471 400 |
| | Europe | 760 700 | (132 400) | | 628 300 |
| | Eastern Mediterranean | 2 833 000 | (934 400) | 410 000 | 2 308 600 |
| | Western Pacific | 1 340 700 | 773 300 | | 2 114 000 |
| | Global and interregional | 3 018 700 | 19 200 | | 3 037 900 |
| | **Total** | **13 980 100** | **(1 094 200)** | **800 100** | **13 686 000** |
| **3.4** | **Quality of care and health technology** | | | | |
| | Africa | 1 871 500 | (828 100) | | 1 043 400 |
| | The Americas | 351 200 | (1 000) | | 350 200 |
| | South-East Asia | 4 792 200 | (1 091 700) | | 3 700 500 |
| | Europe | 1 045 900 | 44 700 | | 1 090 600 |
| | Eastern Mediterranean | 3 195 000 | 531 400 | (390 000) | 3 336 400 |
| | Western Pacific | 2 714 800 | (172 500) | | 2 542 300 |
| | Global and interregional | 9 815 000 | (342 900) | | 9 472 100 |
| | **Total** | **23 785 600** | **(1 860 100)** | **(390 000)** | **21 535 500** |
| | **Total: Appropriation section 3** | **170 858 200** | **(8 355 800)** | **3 787 800** | **166 290 200** |

| | Regular budget | | | |
|---|---|---|---|---|
| | 1996-1997 | Programme changes presented at Executive Board ninety-ninth session | Further net shifts before Fiftieth World Health Assembly | 1998-1999 |
| **4.1 Reproductive, family and community health and population issues** | | | | |
| Africa | 5 271 600 | 2 182 400 | | 7 454 000 |
| The Americas | 3 460 200 | (159 800) | | 3 300 400 |
| South-East Asia | 6 115 400 | (446 400) | | 5 669 000 |
| Europe | 1 694 600 | (374 300) | | 1 320 300 |
| Eastern Mediterranean | 2 321 000 | (239 400) | | 2 081 600 |
| Western Pacific | 2 535 700 | 252 600 | | 2 788 300 |
| Global and interregional | 8 618 900 | (201 800) | 102 400 | 8 519 500 |
| **Total** | **30 017 400** | **1 013 300** | **102 400** | **31 133 100** |
| **4.2 Healthy behaviour and mental health** | | | | |
| Africa | 5 008 200 | (26 200) | | 4 982 000 |
| The Americas | 1 839 200 | 295 900 | | 2 135 100 |
| South-East Asia | 5 305 200 | (537 200) | | 4 768 000 |
| Europe | 3 772 300 | (1 370 900) | | 2 401 400 |
| Eastern Mediterranean | 2 441 200 | 1 190 500 | (100 000) | 3 531 700 |
| Western Pacific | 3 422 500 | 1 094 800 | | 4 517 300 |
| Global and interregional | 11 880 700 | (1 180 300) | (102 400) | 10 598 000 |
| **Total** | **33 669 300** | **(533 400)** | **(202 400)** | **32 933 500** |
| **4.3 Nutrition, food security and safety** | | | | |
| Africa | 2 517 200 | (558 500) | | 1 958 700 |
| The Americas | 3 101 800 | (452 300) | 150 000 | 2 799 500 |
| South-East Asia | 3 440 800 | (829 200) | 115 800 | 2 727 400 |
| Europe | 467 000 | 347 300 | | 814 300 |
| Eastern Mediterranean | 988 900 | 481 300 | | 1 470 200 |
| Western Pacific | 1 304 800 | 369 500 | | 1 674 300 |
| Global and interregional | 7 164 000 | (499 400) | | 6 664 600 |
| **Total** | **18 984 500** | **(1 141 300)** | **265 800** | **18 109 000** |

| | Regular budget | | | |
|---|---|---|---|---|
| | 1996-1997 | Programme changes presented at Executive Board ninety-ninth session | Further net shifts before Fiftieth World Health Assembly | 1998-1999 |
| **4.4 Environmental health** | | | | |
| Africa | 8 091 900 | (632 800) | | 7 459 100 |
| The Americas | 8 721 200 | (1 217 600) | 567 700 | 8 071 300 |
| South-East Asia | 6 359 500 | (140 900) | 345 500 | 6 564 100 |
| Europe | 2 730 100 | 1 338 100 | | 4 068 200 |
| Eastern Mediterranean | 4 919 700 | 1 038 500 | | 5 958 200 |
| Western Pacific | 6 602 900 | (1 698 800) | | 4 904 100 |
| Global and interregional | 12 099 900 | 236 700 | | 12 336 600 |
| **Total** | **49 525 200** | **(1 076 800)** | **913 200** | **49 361 600** |
| **Total: Appropriation section 4** | **132 196 400** | **(1 738 200)** | **1 079 000** | **131 537 200** |
| **5.1 Eradication/elimination of specific communicable diseases** | | | | |
| Africa | 145 700 | 908 200 | | 1 053 900 |
| The Americas | 578 800 | (289 800) | | 289 000 |
| South-East Asia | 982 300 | 959 300 | | 1 941 600 |
| Europe | | 206 000 | | 206 000 |
| Eastern Mediterranean | 43 200 | 1 620 100 | | 1 663 300 |
| Western Pacific | 81 000 | 423 000 | | 504 000 |
| Global and interregional | 4 507 600 | 2 162 000 | | 6 669 600 |
| **Total** | **6 338 600** | **5 988 800** | **0** | **12 327 400** |
| **5.2 Control of other communicable diseases** | | | | |
| Africa | 16 165 800 | 764 000 | | 16 929 800 |
| The Americas | 14 231 500 | (214 500) | | 14 017 000 |
| South-East Asia | 11 043 000 | 2 078 000 | | 13 121 000 |
| Europe | 1 564 300 | 329 500 | | 1 893 800 |
| Eastern Mediterranean | 11 345 300 | (2 209 000) | | 9 136 300 |
| Western Pacific | 11 429 100 | (837 700) | | 10 591 400 |
| Global and interregional | 33 525 100 | 4 277 300 | | 37 802 400 |
| **Total** | **99 304 100** | **4 187 600** | **0** | **103 491 700** |

| | Regular budget | | | |
|---|---|---|---|---|
| | 1996-1997 | Programme changes presented at Executive Board ninety-ninth session | Further net shifts before Fiftieth World Health Assembly | 1998-1999 |
| **5.3 Control of noncommunicable diseases** | | | | |
| Africa | 1 346 500 | (3 600) | | 1 342 900 |
| The Americas | 1 982 100 | 195 300 | | 2 177 400 |
| South-East Asia | 2 847 600 | 468 400 | (305 100) | 3 010 900 |
| Europe | 938 000 | (113 700) | | 824 300 |
| Eastern Mediterranean | 2 060 600 | (251 000) | (50 000) | 1 759 600 |
| Western Pacific | 2 241 000 | 341 500 | | 2 582 500 |
| Global and interregional | 5 045 300 | (105 700) | | 4 939 600 |
| **Total** | **16 461 100** | **531 200** | **(355 100)** | **16 637 200** |
| **Total: Appropriation section 5** | **122 103 800** | **10 707 600** | **(355 100)** | **132 456 300** |
| **6.1 Personnel** | | | | |
| Africa | 1 835 100 | 353 400 | | 2 188 500 |
| The Americas | 1 112 200 | (102 700) | | 1 009 500 |
| South-East Asia | 507 700 | 186 900 | | 694 600 |
| Europe | 1 237 000 | 116 600 | | 1 353 600 |
| Eastern Mediterranean | 620 100 | 149 900 | | 770 000 |
| Western Pacific | 701 900 | 27 200 | | 729 100 |
| Global and interregional | 10 307 800 | 520 600 | | 10 828 400 |
| **Total** | **16 321 800** | **1 251 900** | **0** | **17 573 700** |
| **6.2 General administration** | | | | |
| Africa | 14 981 700 | (485 200) | | 14 496 500 |
| The Americas | 3 173 900 | (244 200) | | 2 929 700 |
| South-East Asia | 3 131 000 | (399 800) | | 2 731 200 |
| Europe | 8 963 900 | (471 700) | | 8 492 200 |
| Eastern Mediterranean | 3 903 400 | (201 200) | | 3 702 200 |
| Western Pacific | 4 522 700 | (268 800) | | 4 253 900 |
| Global and interregional | 56 834 800 | (895 100) | | 55 939 700 |
| **Total** | **95 511 400** | **(2 966 000)** | **0** | **92 545 400** |

| | Regular budget | | | |
|---|---|---|---|---|
| | 1996-1997 | Programme changes presented at Executive Board ninety-ninth session | Further net shifts before Fiftieth World Health Assembly | 1998-1999 |
| **6.3 Budget and finance** | | | | |
| Africa | 3 133 900 | 131 800 | | 3 265 700 |
| The Americas | 1 516 700 | (22 400) | | 1 494 300 |
| South-East Asia | 752 500 | 212 900 | | 965 400 |
| Europe | 2 069 600 | 355 100 | | 2 424 700 |
| Eastern Mediterranean | 1 050 900 | 51 300 | | 1 102 200 |
| Western Pacific | 1 003 300 | 241 600 | | 1 244 900 |
| Global and interregional | 17 623 400 | (313 000) | | 17 310 400 |
| **Total** | **27 150 300** | **657 300** | **0** | **27 807 600** |
| **Total: Appropriation section 6** | **138 983 500** | **(1 056 800)** | **0** | **137 926 700** |
| **GRAND TOTAL** | **842 654 000** | **0** | **0** | **842 654 000** |

# PART IV

# PROPOSED COST INCREASES AND CURRENCY ADJUSTMENTS

43. Projections by the Director-General for cost increases and the impact of currency fluctuations on the proposed programme budget for 1998-1999 were studied by the Executive Board in January 1997.[1] The proposal was to maintain zero real growth, in view of the substantial real reduction already made in 1996-1997 and the perceived programme needs in 1998-1999. The maintenance of zero real growth required a 2% nominal increase in the budget, the impact of 4% inflation worldwide being offset by a 2% reduction due to exchange rate adjustments.

44. The Board did not, however, reach a consensus on the proposed 2% increase. Both its Administration, Budget and Finance Committee and Programme Development Committee had supported the increase and a number of Board members also shared this view when the matter came before the full Board. Other Board members, however, favoured a policy of zero nominal growth, or a lesser figure, in the budget, citing overall public expenditure constraints and difficulties in meeting contributions. In summing up the debate, the Chairman noted that the views expressed had reflected the diversity of WHO's membership and that no consensus had emerged on whether to recommend a 2% increase or zero nominal growth.

45. The Director-General has reviewed the situation with respect to cost increases and currency fluctuations since the Board session. No change is indicated at present with respect to the proposed 4% cost increase to cover expected inflation for the two years. There have, however, been developments pertaining to currency fluctuations which would, if the situation as of March 1997 is maintained up to the Health Assembly, lead to a reduction of the budget level by 3.6% as a result of exchange rate adjustments. The following table shows the situation by office and by appropriation section.

[1] Document EB99/10.

| | Proposed programme budget for 1998-1999 at 1996-1997 costs and exchange rates | Proposed cost increases | | Potential exchange rate adjustments | | Proposed programme budget for 1998-1999 at estimated 1998-1999 costs and exchange rates | |
|---|---|---|---|---|---|---|---|
| | US $ | US $ | % | US $ | % | US $ | %* |
| **Summary by office** | | | | | | | |
| Africa | 154 310 000 | 6 462 500 | *4.2* | (2 712 500) | *(1.8)* | 158 060 000 | *2.4* |
| The Americas | 79 794 000 | 3 232 000 | *4.1* | 0 | | 83 026 000 | *4.1* |
| South-East Asia | 96 220 000 | 4 034 300 | *4.2* | (595 300) | *(0.6)* | 99 659 000 | *3.6* |
| Europe | 51 164 000 | 2 048 200 | *4.0* | (3 184 200) | *(6.2)* | 50 028 000 | *(2.2)* |
| Eastern Mediterranean | 86 258 000 | 4 362 000 | *5.1* | 0 | | 90 620 000 | *5.1* |
| Western Pacific | 76 709 000 | 4 067 600 | *5.3* | (167 600) | *(0.2)* | 80 609 000 | *5.1* |
| Global and interregional | 298 199 000 | 9 385 900 | *3.2* | (23 468 900) | *(7.9)* | 284 116 000 | *(4.7)* |
| **Total** | **842 654 000** | **33 592 500** | ***4.0*** | **(30 128 500)** | ***(3.6)*** | **846 118 000** | ***0.4*** |
| **Summary by appropriation section** | | | | | | | |
| Section 1 | 19 543 900 | 650 800 | *3.3* | (780 400) | *(4.0)* | 19 414 300 | *(0.7)* |
| Section 2 | 254 899 700 | 10 048 100 | *3.9* | (7 796 300) | *(3.0)* | 257 151 500 | *(0.9)* |
| Section 3 | 166 290 200 | 6 860 100 | *4.1* | (2 343 600) | *(1.4)* | 170 806 700 | *2.7* |
| Section 4 | 131 537 200 | 5 547 900 | *4.2* | (2 907 400) | *(2.2)* | 134 177 700 | *2.0* |
| Section 5 | 132 456 300 | 5 617 100 | *4.2* | (2 415 600) | *(1.8)* | 135 657 800 | *2.4* |
| Section 6 | 137 926 700 | 4 868 500 | *3.5* | (13 885 200) | *(10.1)* | 128 910 000 | *(6.6)* |
| **Total** | **842 654 000** | **33 592 500** | ***4.0*** | **(30 128 500)** | ***(3.6)*** | **846 118 000** | ***0.4*** |

* The percentage given is the total change due to cost and exchange rate adjustments.

46. The overall increase required to achieve zero real growth, based on the exchange rate situation as of March 1997, is therefore 0.4% only. On this basis, the Director-General is proposing to the Health Assembly an overall budget of US$ 846 118 000. He will of course report further to the Assembly if there is any significant change in the situation as regards cost increases or currency fluctuations prior to its consideration of the budget proposals.

# PART V

# MATTERS FOR THE PARTICULAR ATTENTION OF THE HEALTH ASSEMBLY

47. The Health Assembly, after reviewing the present document in conjunction with the proposed programme budget for 1998-1999, may wish:

- to note that most of the provisions of resolutions EB95.R4, WHA48.25 and EB97.R4 have been fulfilled by presentation of the proposed programme budget for 1998-1999;

- to note that a number of the provisions of resolution EB99.R13 have been fulfilled by the presentation of the present document;

- to request the Executive Board to follow up the further elements of programme budget reform as outlined in resolution EB99.R13;

- after reviewing more particularly Part II and Part IV of the present document, to endorse the changes proposed by the Director-General and modified in the light of its discussion.

48. The Health Assembly is invited to consider the following resolution in connection with the proposal relating to the cost of travel to the Health Assembly contained in appropriation section 1 of the proposed programme budget:

The Fiftieth World Health Assembly,

Recalling resolution WHA30.11 on reimbursement of travelling expenses for attendance at the Health Assembly;

Having considered the proposed programme budget for the financial period 1998-1999, in particular appropriation section 1, Governing bodies;

Noting the proposal contained therein that the Organization should meet the cost of travel to the Health Assembly for one representative each from the least developed countries only, in order to keep costs of governing bodies within the level budgeted for 1996-1997,

DECIDES that, with effect from 1 January 1998, only Members that are classified as least developed countries shall be reimbursed for the actual travelling expenses of one delegate each, the maximum reimbursement to be restricted to the equivalent of one economy/tourist return air ticket from the capital city of the Member to the place of the session.

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