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WORLD HEALTH ORGANIZATION

PROGRAMME BUDGET 2002–2003

PERFORMANCE ASSESSMENT REPORT

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FOREWORD

The Programme budget 2002-2003 – performance assessment report provides an Organization-wide summary of performance, together with the broader lessons learnt in using the WHO results-based management framework. For each area of work, a detailed performance analysis is provided, including the following: a summary of overall achievements recorded and expected results delivered; a discussion of critical impediments encountered; an assessment of the relevance and adequacy of the expected results for achieving the WHO objectives; information on expenditure; and an explanation of the key lessons learnt. The performance assessment of the Programme budget 2002-2003 is part of a series of actions aimed at improving technical and managerial performance and providing greater accountability.

This report enables us for the first time to "visualize" the results that the Organization committed itself to achieving in the programme budget. During the 2002-2003 biennium we witnessed many important achievements: the rapid and effective response to the outbreak of severe acute respiratory syndrome; the elimination of poliomyelitis in all but six countries; the adoption of the Framework Convention on Tobacco Control; the greater emphasis placed on HIV/AIDS treatment; the expansion of directly observed treatment, short course for tuberculosis in all regions; the strengthening of health systems at country level; and the higher profile given to health as an issue for sustainable development.

There has recently been a major focus on improving management and increasing dialogue and collaboration throughout the Organization: results-based management is being implemented, a human resources reform process has been initiated, and financial management has been further strengthened; improvements have also been made in the planning, targeting and projection of resource requirements, the mobilization of resources, and in monitoring and evaluation activities. However, we need to ensure greater consistency across areas of work; resources at the regional and country levels also need to be increased. It was with this in mind that I made my commitment to ensure a better balance of resources for regions, countries and headquarters, advancing towards a target for 2004-2005 of 70% for regions and countries and 30% for headquarters.

The lessons learnt in applying the WHO results-based framework and implementing the Programme budget 2002-2003 will continue to be incorporated into the managerial process in order to improve programme delivery. They have already proved extremely useful in the preparation of the Proposed programme budget 2006-2007.

LEE Jong-wook

Director-General

Geneva, November 2004

HIGHLIGHTS OF ACHIEVEMENTS

WHO has established a results-based management framework which ensures that programmes are formulated against a set of objectives and expected results. The expected results, which the Secretariat is committed to achieving over the biennium, form the basis for determining resource requirements and justify resource allocation in the programme budget. The actual achievements in implementing the programme budget are measured by performance indicators. This report provides a detailed assessment of achievements for each of the 34 areas of work. Some of the most significant achievements in implementing the Programme budget 2002-2003 are described below.

In the area of *epidemic alert and response*, WHO played a key role in containing emerging and potentially epidemic infectious diseases that posed a global public health threat. The Organization was active in collecting information, coordinating international outbreak response activities, setting standards, and supporting countries in disease surveillance and response. The work performed in recent years made it possible to mount rapid responses to several disease outbreaks in 2002 and 2003, the most important being the outbreak of *severe acute respiratory syndrome (SARS)*. From the outset, an unprecedented level of global cooperation, coordinated by WHO, allowed scientists to identify SARS and learn how to contain it. Within a month, a new coronavirus was identified as the cause of the disease and after four months, WHO was able to report that the human-to-human transmission of SARS had been broken worldwide. WHO's coordination of the global response to SARS highlights the Organization's unique role in this area, in accordance with its global public health mandate.

In the fight against tuberculosis, substantial progress in the expansion of *directly observed treatment, short course (DOTS)* was achieved in all regions. Twenty-five additional countries implemented the DOTS strategy during 2002-2003, bringing the total to 180 countries out of a total of 210. By the end of 2002, 69% of the world's population was living in countries where DOTS was provided and since its development by WHO and its partners, DOTS treatment has saved hundreds of thousands of lives. This major achievement was celebrated with the launch of the 2003 report on global tuberculosis control.[1] With HIV fuelling epidemics of tuberculosis in many areas of the world, during the biennium WHO continued its work, strengthening partnerships at country and regional levels, providing guidance on global strategies and policies and developing efficient and effective management of the Stop TB Partnership. In the area of *malaria* control, antimalarial drug resistance continues to be a major source of concern and antimalarial resistance and drug policy networks were expanded in all regions, with 19 additional countries adopting artemisinin-based combination therapy as first- or second-line treatment for falciparum malaria.

WHO continued to strengthen its technical involvement in activities to combat *HIV/AIDS*. As the lead agency for the health-sector response to the disease, the Organization developed the global health-sector strategy for HIV/AIDS, which was adopted by the Fifty-sixth World Health Assembly in May 2003.[2] The strategy describes effective health-sector interventions against HIV/AIDS and provides Member States with guidance on incorporating them into health systems. The strategy was also adapted in several WHO regions, where it guided national HIV/AIDS strategy and policy development, linking care and prevention in 40 countries. The International HIV Treatment Access Coalition was launched as a partnership to promote expanded access to antiretroviral therapy, and more than 140 partner organizations joined. Two editions of guidelines for a public health approach of antiretroviral treatment in resource-limited settings were also produced in order to simplify the delivery of antiretroviral therapy and clinical follow-up in developing countries.[3] In addition, 2003 saw the launch of the "3 by 5" initiative, an ambitious strategy to provide antiretroviral therapy to three million people living with HIV/AIDS by the end of 2005. By the end of the period under consideration, 35 countries had asked to participate in the initiative, which is supported by all UNAIDS cosponsors.

In the field of *child and adolescent health*, major milestones were achieved during the biennium. Recognizing that approximately 40% of the global burden of disease falls on children and adolescents, the Fifty-sixth World Health Assembly welcomed WHO's strategic directions for improving the health and development of children and adolescents;[4] the directions are already being used by a number of countries to develop comprehensive national child and adolescent health policies. In addition, implementation of the strategy for the Integrated Management of Childhood Illness (IMCI) reached the 100-country mark. Of 73 countries with an infant mortality rate of 40 deaths or more of per 1000 live births, 71 began implementing IMCI. Among these countries, 54

[1] Global tuberculosis control: surveillance, planning, financing. WHO report 2003 (document WHO/CDS/TB/2003.316).

[2] See resolution WHA56.30.

[3] *Scaling up antiretroviral therapy in resource-limited settings: guidelines for a public health approach*. Geneva, World Health Organization, 2002; *Scaling up antiretroviral therapy in resource-limited settings: treatment guidelines for a public health approach. 2003 revision*. Geneva, World Health Organization, 2004.

[4] See resolution WHA56.21.

incorporated IMCI into their national health policies or plans. This is especially important as preliminary results of a multicountry evaluation of IMCI have demonstrated that it can decrease child mortality rates at no extra cost. A further advance was marked by the adoption of the global strategy for infant and young child feeding by the Fifty-fifth World Health Assembly in May 2002.[1]

During the biennium, the *Global Polio Eradication Initiative* shifted its strategy to focus more sharply on the six countries in which poliomyelitis transmission continued: Afghanistan, Egypt, India, Niger, Nigeria and Pakistan; three of these (India, Nigeria and Pakistan) accounted for more than 90% of total cases. In India, in April 2003, WHO, UNICEF and their partners began a campaign to vaccinate more than 80 million children in six Indian states. During the biennium, the WHO European Region was certified free of poliomyelitis. This was the third region to be certified, following the WHO Region of the Americas and the WHO Western Pacific Region. The progress achieved in moving closer to the goal of poliomyelitis eradication was clear evidence of the firm commitment of all Member States, WHO and partners to this effort.

Immunization is one of the most cost-effective interventions available and substantial progress was made in this area during 2002-2003; as a result, 85% of Member States are now implementing strategies for accelerated measles control. The Organization, in close collaboration with the Global Alliance for Vaccines and Immunization, continued to collaborate with countries in expanding the use of new or underutilized vaccines. The safety of immunzation increased through the use of vaccines of assured quality in 91% of Member States and in 35% of countries improvements were recorded in monitoring and management systems for adverse events following immunization.

In May 2003, the *WHO Framework Convention on Tobacco Control (FCTC)* was unanimously adopted by the Fifty-sixth World Health Assembly – a landmark event in the history of the Organization and public health in general.[2] This achievement reflected WHO's commitment to reducing global tobacco consumption and cutting the number of tobacco-related deaths. Following adoption of the Convention, subregional awareness-raising workshops for 22 countries were held in the African, European and Eastern Mediterranean Regions. Over 130 countries received support from WHO to run media and advocacy campaigns and more than 50 countries carried out World No Tobacco Day activities in 2002 and 2003.

Chronic diseases, accounting every year for almost 60% of all deaths and 47% of the global burden of disease, represent a growing problem in developing countries. During the biennium, WHO continued its efforts to raise awareness on this subject, develop guidelines for priority noncommunicable diseases and support community-based prevention programmes for noncommunicable diseases in all regions. As part of this work, broad and inclusive consultations were held on a global strategy on diet, physical activity and health.[3]

Achievements in the area of *mental health* included the development of the Organization-wide strategy, the mental health Global Action Programme; WHO also provided global data on mental health systems to 191 countries. Advocacy groups aiming to raise awareness concerning mental and neurological disorders and substance abuse were created in 19 countries.

The importance of health, both in its own right and a major factor underlying economic development and poverty reduction, is now more widely recognized by governments and civil society. Health featured prominently in the discussions at the International Conference on Financing for Development (Monterrey, Mexico, 2002), the Fourth WTO Ministerial Conference (Doha, 2001) and the World Summit on Sustainable Development (Johannesburg, South Africa, 2002). It is widely acknowledged that WHO has made a contribution to raising the profile of health as an issue in *sustainable development*. During the biennium, the findings of the WHO Commission on Macroeconomics and Health, for instance, were widely quoted in the media, and in academic and national policy settings; capacity-building materials on health were also developed in the poverty reduction strategy papers, and, as a consequence, three regional offices began defining regional policy frameworks for health and poverty reduction.

In the area of *emergency preparedness and response*, the number of operations supported by WHO increased from 46 to 122 during the biennium, indicating growing organizational readiness. During the same period, a new alliance in the area of *health and environment*, Healthy Environments for Children, was launched jointly with a number of international and national partners from all sectors to tackle the issue of providing children with safe water and food, universal sanitation and clean air.

Work on human resources for health continued during the biennium, involving efforts to strengthen national capacity and *health systems* at country level. The WHO Regional Offices for South-East Asia and the Eastern Mediterranean supported quality improvement in health services through professional development and an accreditation process was introduced in several

[1] See resolution WHA55.25.

[2] See resolution WHA56.1.

[3] The global strategy on diet, physical activity and health was subsequently adopted at the Fifty-seventh World Health Assembly in May 2004 (see resolution WHA57.17).

countries. In addition, all regions continued to provide support for the strengthening of *health information* and vital registration systems. In the WHO European Region, implementation of the tenth revision of the International Statistical Classification of Diseases and Related Health Problems was expanded to cover 82% of the Region. In the WHO South-East Asia Region, the majority of countries completed assessments of their health information systems with a view to strengthening them. In the area of *health research*, the report on genomics and world health, drawn up by WHO's Advisory Committee on Health Research, was well received by the international health and scientific community and widely commented upon by the international media.[1]

In order to improve the way WHO is managed, a *human resource reform* process was initiated; this resulted in new policies and procedures, including the draft policy on staff rotation and mobility. A review was also undertaken concerning staff members on short-term contracts for a long period, so-called "long-term, short-term staff". Following this, the system of service appointments was successfully introduced. In addition, the e-recruitment system was implemented worldwide, and a competency-based framework was developed for job classification, recruitment, performance evaluation, development training needs assessment and development of learning programmes. In the area of *financial management*, investment earnings exceeded benchmarks established in relation to investment policy parameters and financial reports accurately reflected transactions as they were recorded. Important gains were also achieved in WHO's drive to institutionalize *results-based management* with the completion of an integrated results-based framework including planning, budgeting, monitoring and evaluation. Use of results-based budgeting in the regions led to the strengthening of monitoring and feedback procedures and improved the quality of reporting to the governing bodies. A headquarters review indicated that more than 90% of products had been assessed in the activity management system – a sign of improved monitoring.

CHALLENGES AND CONSTRAINTS IN IMPLEMENTING THE PROGRAMME BUDGET 2002-2003

The importance of *partnerships* and the need to involve key stakeholders are mentioned throughout in the report. Although it was already well acknowledged that there was a need for partnerships, their development and use continued to pose a challenge during the period under review. Constraints included the following: limited human resources; lack of qualified staff; organizational fragmentation; ill-defined operational procedures; and a complex environment with a large number of partnerships, in some of which there was a lack of clarity concerning WHO's roles and responsibilities. The need for intersectoral collaboration was recognized as well as the importance of the role that nongovermental organizations can play as facilitators of policy change. However, it was felt that WHO was not yet sufficiently equipped to deal with these new partners. Partnerships were considered particularly important in relation to health issues that might not be high on all national agendas. These include areas like health promotion, injuries, mental health, gender and environmental determinants of health. However, sustained advocacy efforts are needed to ensure commitments, while limited human resources remain a constraint.

Insufficient financial resources represented a major obstacle to achieving the expected results. Successful implementation of activities in headquarters, regions and countries was further impeded by inadequate human resources competence. Many areas of work reported that weaknesses in national capacity to implement promotion and prevention activities and the lack of functioning health services also constituted major obstacles to progress. Limitations in technical and managerial capacity at national level, high turnover rates among skilled professionals (including departures motivated by a desire for better opportunities) were seen as further constraints. These issues were considered extremely complex, calling for flexible cross-sectoral approaches, in addition to strong political will.

IMPLEMENTATION OF RESULTS-BASED BUDGETING WITHIN THE CONTEXT OF THE RESULTS-BASED MANAGEMENT FRAMEWORK

The following lessons are derived from the performance analysis by individual area of work, reflecting elements that are common to the work of the Organization as a whole.

Changes in the process for preparing the proposed programme budget, which were designed to encourage a more collaborative approach, resulted in *increased dialogue among all levels of the Organization.* Benefiting from greater inputs from the country offices, regional offices worked with headquarters in drafting the proposed programme budget. In the regions, country inputs were based on national health strategies and priorities, as well as the priorities for WHO action as identified in WHO country cooperation strategies or equivalent strategic planning processes. Regional offices then synthesized individual country inputs, identifying commonalities to be included in the proposed programme budget. The successive stages in this process

[1] *Genomics and world health: report of the Advisory Committee on Health Research.* Geneva, World Health Organization, 2002.

allowed for *better communication and coordination between the various levels*, while respecting regional and national differences within agreed Organization-wide objectives and strategies.

WHO's governing bodies (including the regional committees), together with WHO partners and donors, commended the Organization's move to establish results-based budgeting within a broader framework of results-based management. For the first time, assisted by performance monitoring, evaluation and reporting on expected results, the governing bodies were able to observe the results that the Organization had committed itself to achieving, thereby making WHO *more transparent and accountable.* Furthermore, senior staff began increasingly to manage in terms of results, drawing on and applying knowledge gained during implementation.

Implicit in the collaborative planning process is a shared responsibility for achieving Organization-wide expected results and the assumption that the different levels and offices will undertake the activities necessary to ensure success. This assumption did not hold true for all areas of work: although the expected results are adopted by the governing bodies for the Organization as a whole, the regional and country offices sometimes give priority to locally defined needs; at the global level, Organization-wide commitments were on occasion considered synonymous with activities at headquarters. This perspective has an impact on joint planning among organizational levels and on resource allocation and programme implementation. In such instances, *countries and regions do not always programme in support of Organization-wide expected results* or report on efforts contributing to the achievement of global expected results.

In keeping with WHO's results-based management, the programme budget must state what the Organization will accomplish collectively over the biennium. The nature of the Organization and the geographical scope of its programmes mean that Organization-wide expected results have to be broad enough to accommodate the unique needs of Member States, while remaining sufficiently specific to ensure that desired results are expressed clearly and that accountability is facilitated. This balance is not easy to strike and *some of the expected results are formulated in a highly abstract manner*, which provides insufficient guidance for developing workplans and makes it difficult to gauge the success of the Organization's efforts.

The programme budget provides a strategic framework and common objectives for WHO's work. However, timeframes imposed by the programme budget cycle may mean that regional and country offices draw up their operational plans before finalization of the proposed programme budget, or simultaneously with it; this can have an adverse effect on *consistency and linkage between strategic and operational planning.*

The challenge of ensuring this consistency is further illustrated during resource allocation. The Organization-wide expected results and the integrated budget for areas of work are vertical in nature, cutting across the three levels of the Organization; budget allocations are still partly horizontal: regions receive an allocation, which they distribute at their discretion among areas of work, at their level; the country offices, which receive their allocation from the regional office, do likewise. The challenge is to *ensure that actual allocations at the different levels reflect the resources required to achieve the contribution of regional and country offices to Organization-wide expected results* that have been agreed upon collectively.

Results-based management as implemented in WHO encourages the following improvements: a greater degree of interdependence across levels and among offices; an element of uniformity of processes; greater managerial responsibility; and a greater acceptance of and compliance with Organization-wide business rules than was previously the case. Similarly, results-based management also generates a need to improve accountability, demonstrate results and display a sharper focus within and across programmes. Furthermore, it creates the expectation that programmes adopt a "planning, performance monitoring, evaluation, and reporting culture" that does not encourage ad hoc programming and resource mobilization. The *challenges inherent in making these changes in organizational culture* are real and remains a significant factor in the introduction and effective application of results-based management during the period under review.

The Way Forward

Reporting on the achievement of Organization-wide expected results was hindered by indicators that were poorly chosen and drafted or that required data that were incomplete or unavailable. *Many of the targets were not easily measurable, and weaknesses in the baseline data for the indicators* were also observed. Indicators, targets and baseline data have therefore been refined in order to measure more accurately the achievement of the Organization-wide expected results in the Programme budget 2004-2005. A practical, detailed guide for developing expected results, indicators, targets, and baselines has been prepared and disseminated throughout the Organization so that similar problems can be avoided during the preparation of the Proposed programme budget 2006-2007; training courses and seminars have also been held for regional and headquarters staff. A review of indicators is being undertaken as part of the programme budget preparation process in order to ensure technical quality and practicality.

Close coordination between the three levels of the Organization is a crucial factor for success in many of the areas of work and is essential for the effective operation of the WHO results-based management framework and its integrated "one WHO" programme budget. Coordination is currently being strengthened through greater emphasis on a joint approach to planning, performance monitoring, and evaluation. Greater reliance will be placed on the country cooperation strategy in order to maximize inputs from countries in the preparation of the Proposed programme budget 2006-2007. The joint planning process will identify what is required from countries, regions, and headquarters in order to achieve the Organization's expected results, and will ensure that the contributions of each office that have been agreed upon collectively are reflected in their workplans.

In order to function as a single instrument for the whole Organization*, the programme budget must effectively integrate different sources of funding*. The breakdown for the regular budget and "other sources" needs to be the basis for mobilization, prioritization and allocation of funds across areas of work and by organizational level. In conformity with WHO's Financial Rules, the actual allocation of the regular budget and other sources across areas of work will be adjusted and resources transferred as necessary throughout the biennium to ensure that the total planned costs by area of work are made available. While undertaking these reforms, the challenge will be to maintain "incentives" for programmes or areas of work to mobilize funds from other sources.

Results-based management also requires *clearly defined roles and a robust system for performance monitoring, quality assurance, evaluation and reporting*. Towards that end, specific responsibilities for the development and implementation of results-based management instruments will be defined for each level of the Organization; the framework for performance monitoring and reporting will also be revised in order to provide programme managers with the tools necessary for more effective management.

In order to ensure effective implementation of results-based management, staff skills need to be improved. Beyond the need for general orientation towards results-based management for staff at all levels, including senior management, extensive training is required in the logical framework approach, with particular reference to the formulation of results, indicators, and targets. Tools for quality control of operational and strategic planning are being developed to supplement training offered at country, regional and headquarters levels.

SUMMARY OF FINANCIAL PERFORMANCE 2002-2003

The following table summarizes the Programme budget 2002-2003, adopted by the Fifty-fourth World Health Assembly,[1] which appropriated a regular budget of US$ 842 654 000 and noted estimated expenditure of US$ 1 380 000 000 to be financed from other sources. The table also shows expenditure together with the implementation rate, which is given as a percentage of programme budget by areas of work. As the programme budget represents a single, integrated budget for the Organization as a whole, no distinction is made by source of funds or level of the Organization. The total programme budget adopted by the Health Assembly was US$ 2 222 654 000 and the total expenditure was US$ 2 312 487 000. The average implementation rate across the Organization was 104%; there were, however, wide variations across areas of work.

Table. Programme budget and expenditure by area of work for 2002-2003

Area of work	Programme budget (US$ thousand)	Expenditure (US$ thousand)	Implementation rate as a percentage of programme budget (%)
Communicable disease surveillance	70 743	72 012	101.8
Communicable disease prevention, eradication and control	141 911	144 526	101.8
Research and product development for communicable diseases	88 876	66 696	75.0
Malaria	118 212	89 006	75.3
Tuberculosis	104 650	78 546	75.1
Surveillance, prevention and management of noncommunicable diseases	20 029	22 031	110.0
Tobacco	25 208	22 927	91.0
Health promotion	34 739	31 447	90.5
Disability/injury prevention and rehabilitation	12 047	16 726	138.8

[1] See resolution WHA54.20.

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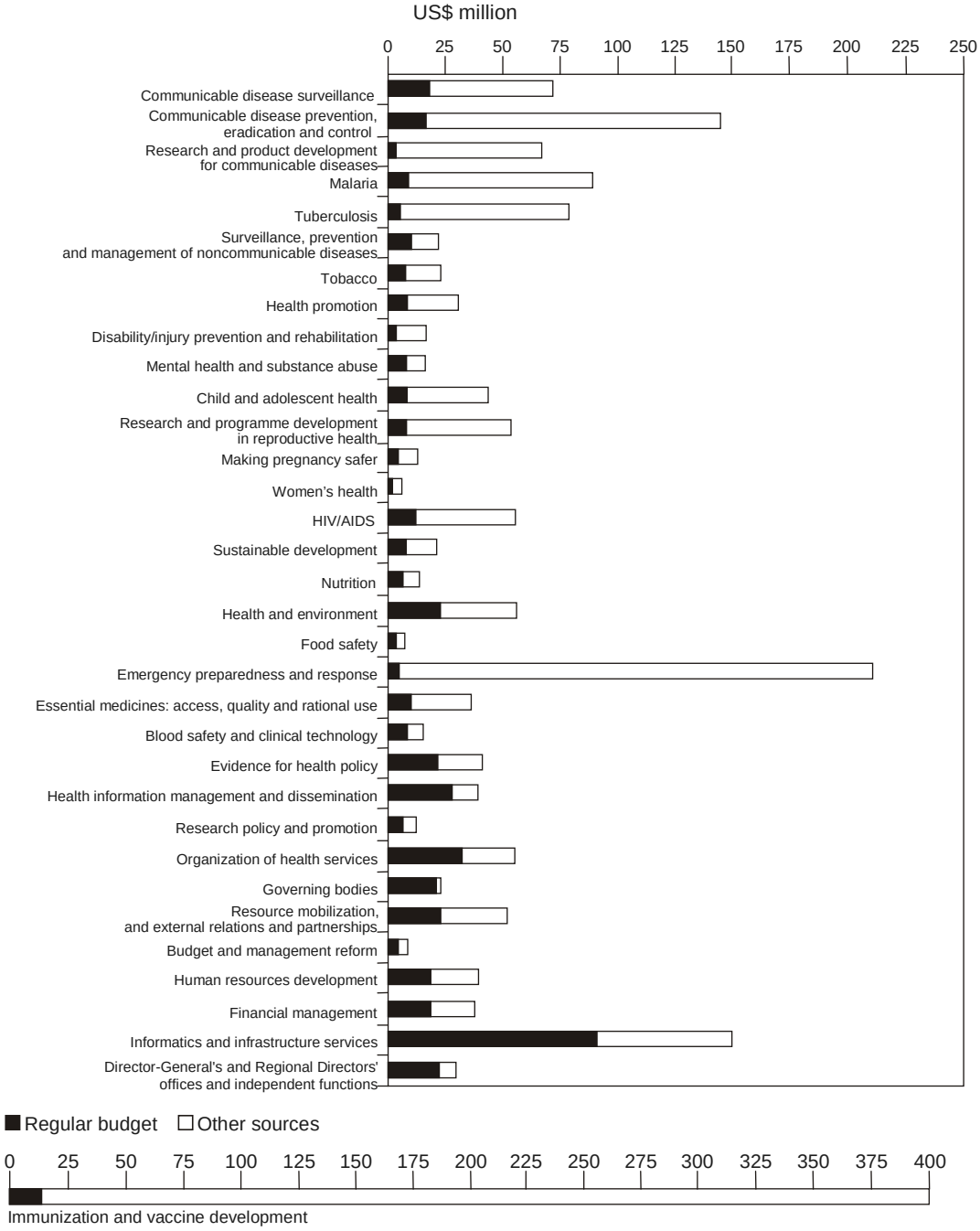
Area of work	Programme budget (US$ thousand)	Expenditure (US$ thousand)	Implementation rate as a percentage of programme budget (%)
Mental health and substance abuse	28 147	16 616	59.0
Child and adolescent health	72 127	44 082	61.1
Research and programme development in reproductive health	67 252	53 903	80.2
Making pregnancy safer	37 157	13 539	36.4
Women's health	15 524	6 472	41.7
HIV/AIDS	129 812	55 854	43.0
Sustainable development	18 419	21 385	116.1
Nutrition	14 475	14 044	97.0
Health and environment	50 076	56 560	112.9
Food safety	10 399	7 940	76.4
Emergency preparedness and response	46 999	210 983	448.9
Essential medicines: access, quality and rational use	42 063	37 015	88.0
Immunization and vaccine development	184 692	401 286	217.3
Blood safety and clinical technology	25 727	15 748	61.2
Evidence for health policy	43 225	41 447	95.9
Health information management and dissemination	46 370	39 506	85.2
Research policy and promotion	11 114	12 551	112.9
Organization of health services	57 923	55 725	96.2
Governing bodies	22 439	23 505	104.8
Resource mobilization, and external cooperation and partnerships	35 307	52 316	148.2
Budget and management reform	7 932	9 348	117.9
Human resources development	21 678	40 624	187.4
Financial management	38 318	38 352	100.1
Informatics and infrastructure services	133 531	150 378	112.6
Director-General, Regional Directors and independent functions	25 028	30 954	80.8
Total – areas of work	**1 801 649**	**1 994 140**	**110.7**
Country programmes	421 005	318 347[1]	75.6
Total – programme budget	**2 222 654[2]**	**2 312 487[3]**	**104.0**

[1] The figure reflects expenditure from the regular budget only. Direct expenditure under country programmes totalling US$ 368 963 000 from other sources is recorded under the area of work where it occurred.

[2] The total budget, which accounts for miscellaneous income of US$ 13 000 000, is US$ 2 236 154 000. The total operational budget, which accounts for total transfers effected and unallocated balance of US$ -16 864 000, is US$ 2 219 290 000. For details, refer to Table 2 in the Financial Report and Audited Financial Statements for the period 1 January 2002 – 31 December 2003 and Report of the External Auditor to the World Health Assembly (see document A57/20).

[3] The total expenditure, which accounts for the expenditure of US$ 4 874 000 from miscellaneous income, is US$ 2 317 361 000. For details, refer to Table 2 in the Financial Report and Audited Financial Statements for the period 1 January 2002 – 31 December 2003 and Report of the External Auditor to the World Health Assembly (ibid.).

Figure 1. Expenditure 2002—2003: by area of work, all offices[1]



WHO 04.158

The above figure notes expenditure by area of work with the breakdown of regular budget and other sources. Within the total expenditure, the largest amount – 17% of the total – was spent on immunization, in particular, the campaign to complete the global eradication of poliomyelitis. The work on emergency preparedness and response, much of which concerned activities in Iraq, accounted for 9% of the total.

[1] Source: Financial Report and Audited Financial Statements for the period 1 January 2002 – 31 December 2003.

Figure 2. Expenditure 2002—2003: by office and source of funds[1]

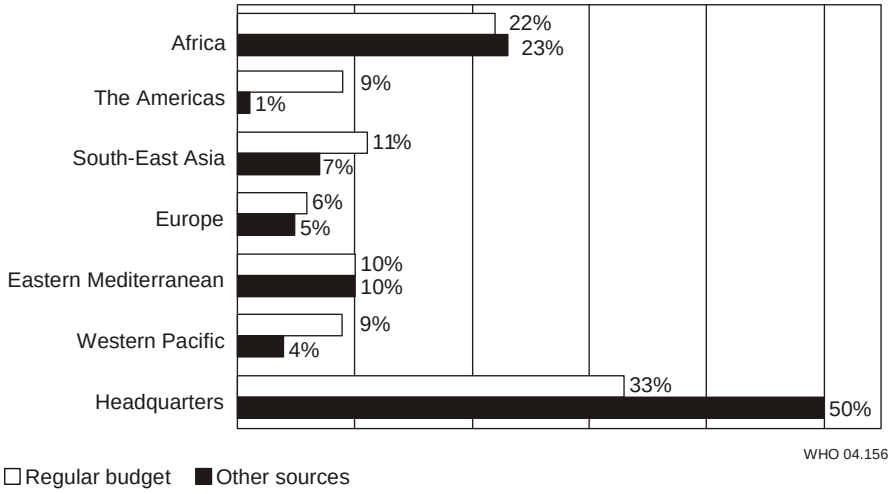
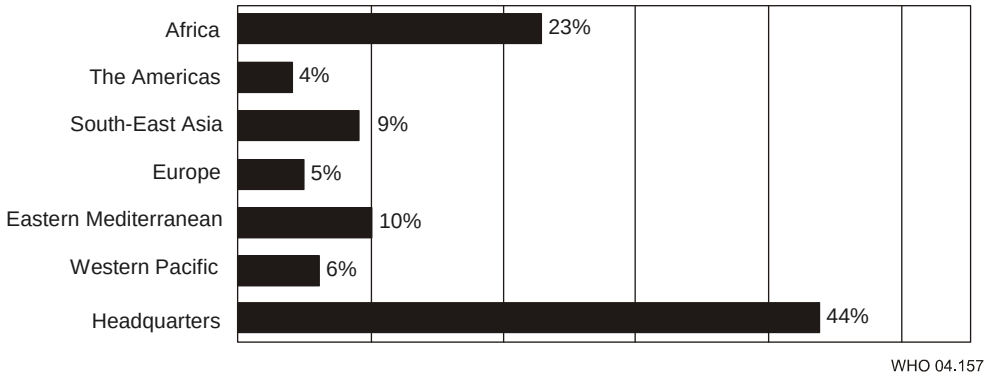


Figure 3. Expenditure 2002—2003: by office, all sources of funds[1]



As illustrated above, during the 2002-2003 biennium headquarters accounted for 44 % of expenditure and regional and country offices 56%. Expenditure ratios for headquarters and regions (including countries) are also shown for the regular budget and for other sources of funds.

[1] Source: Financial Report and Audited Financial Statements for the period 1 January 2002 - 31 December 2003 (Certified 30 March 2004) and Report of the External Auditor to the World Health Assembly (1 April 2004), document A57/20.

PERFORMANCE ASSESSMENT BY AREA OF WORK

COMMUNICABLE DISEASE SURVEILLANCE

WHO objective(s)

To assure that Member States and the international community are better equipped to rapidly detect, define and control threats to public health arising from communicable diseases of known and unknown etiology, including emerging and zoonotic diseases, and from resistance to anti-infective drugs; monitor trends, and use this information to respond effectively.

Summary of achievements

- The level of activities during the biennium and the achievements recorded demonstrated WHO's unique role in global public health security. In keeping with the Organization's health mandate, the Fifty-sixth World Health Assembly, for example, adopted a resolution on the revision of the International Health Regulations.[1]
- Regional capacities for epidemic response, including laboratory capacities, were strengthened and rapid responses to several outbreaks were facilitated as a result. The outbreak of severe acute respiratory syndrome (SARS) was the most important, requiring concerted efforts at all levels of the Organization and unprecedented collaboration among partners in the Global Outbreak Alert and Response Network.
- In parallel and based on WHO's strategy and guidelines, surveillance systems assessment was carried out at country level, enabling the formulation of national plans for integrated disease surveillance and response.

Illustration of achievements at country, regional or global levels

- In the WHO South-East Asia Region, a high-level task force set up by the Regional Director included multi-disease surveillance and response.
- The SARS outbreak raised media interest in global health security in general and outbreak response in particular, thus attracting support from various donors, especially at the regional level. In the WHO Western Pacific Region, these funds were used not only for SARS response but also to build capacities in Member States.

Achievement of expected results

Mechanism established within which bilateral donors, nongovernmental organizations, international organizations, the private sector and other WHO partners can work together to strengthen international action and fund-raising in order to upgrade surveillance and response at country level

Indicator	Baseline	Target	Achievement
Number of targeted countries (1) formulating and (2) implementing national plans for communicable disease surveillance and response	Not established	22 countries	22 countries (from the WHO African, European and Eastern Mediterranean Regions) formulated national plans 20 countries implemented their plans
Total volume of financing mobilized for strengthening communicable disease surveillance and response	Not established	Not established	This indicator was not measured as it did not prove effective due to duplication with the Financial Report
Number of partners actively contributing to global communicable disease surveillance and response	Not established	Not established	This indicator was not measured as it duplicated the first indicator of the third expected result

[1] See resolution WHA56.28.

Information on communicable diseases, including emerging diseases, those likely to cause epidemics, zoonoses and outbreaks of unknown etiology, and drug resistance readily accessible for decision-making at national and international levels

Indicator	Baseline	Target	Achievement
Size of audience for existing WHO tools and products, such as the Outbreak Verification List, Web pages, *Weekly Epidemiological Record* and reports	Outbreak Verification List:		
	Distributed weekly	Distribute 53 weeks a year	Timely distribution; key public health professionals in all regions targeted; distributed 53 weeks a year
	1000 subscribers but no clear criteria	Scale down subscribers by establishing criteria	External subscribers reduced to 500 selected public health professionals, based on agreed criteria
	Gaps in geographical coverage	Increase coverage to all six WHO regions	Six WHO regions covered
	50% of WHO Representatives receiving	100% of WHO Representatives receiving	100% of WHO Representatives receiving
	Web pages:		
	Most visited pages on WHO site	Increase web audience by 20% over 2 years	Crucial for disseminating information on epidemic-prone diseases (e.g. influenza, SARS); Communicable disease surveillance and response web pages most visited on WHO web site, web visits increased 15-fold from 2002 to 2003 (over 10 million visits during SARS outbreak)
	80% of technical documents available online	100% of technical documents on communicable disease surveillance and response available online	100% of technical documents on communicable disease surveillance and response available online
	68 items published on disease outbreaks	Increase publication of disease outbreaks by 20%	30% increase in publication of disease outbreaks; 96 daily updates published on SARS
	Weekly Epidemiological Record:		
	Published weekly	Outbreak reports published weekly in every issue and distributed by e-mail alerts within 24 hours of web publication	Timely distribution; focus of reports widened; audience increased; published 52 weeks a year; outbreaks reported in every issue; 95% of reported outbreaks sent by e-mail within 24 hours of web publication
	E-mail alerts with contents list sent weekly to 6000 subscribers	Increase e-mail subscribers by 20%	E-mail subscribers increased to 8000 (35% increase)

Indicator	Baseline	Target	Achievement
Proportion of information provided in official languages of the United Nations system other than English	No consistent data kept; about 5% of technical documents available in French and Spanish	Increase proportion of new documents available on communicable disease surveillance and response: to 50% in French; to 25% in Spanish; to 5% in Arabic, Chinese and Russian	Target not fully reached because of lack of funds Of 25 new technical documents on communicable disease surveillance and response published during 2002-2003, 10 (40%) available in French, 4 (16%) in Spanish and 1 (4%) in Russian

Effective international action coordinated and support provided for national action in response to threats from communicable diseases, including those that are emerging or likely to cause epidemics

Indicator	Baseline	Target	Achievement
Number of additional partners participating in the Global Epidemic Alert and Response Network	70 partners	30 new partners	60 new partners following increased collaboration during SARS outbreak
Number of epidemics responded to and countries supported through international action	Estimate of 250 events, 46% of which verified	Not established as indicator badly formulated	Of 400 events, 71% verified in 2003 Response to more than 80 different epidemics in 70 countries

Networks of centres and laboratories established for diagnosis and surveillance of communicable diseases, including emerging diseases and zoonoses, and drug resistance

Indicator	Baseline	Target	Achievement
Number of additional networks for communicable disease surveillance	10 networks	3 additional networks	8 additional networks
Number of additional countries and institutions participating in networks	100 countries 400 institutions 20% institutions from developing countries	25 additional institutions and countries 25% institutions from developing countries	20 additional countries 70 additional institutions 25% institutions from developing countries

Standards, norms, manuals and guidelines available for surveillance, prevention and containment of communicable diseases including zoonoses, and drug resistance; mechanisms, including training, established for country implementation

Indicator	Baseline	Target	Achievement
Number of new or revised communicable disease topics for which guidelines on surveillance and control have been drawn up	All major surveillance topics or areas (25 in total) needed new or updated surveillance guidelines or other supporting materials and tools	Define guidelines, policies or norms and other technical materials and tools to support surveillance and control for 20 different surveillance topics	Surveillance, prevention and control guidance materials produced on 11 different topics; guidelines on 2 other topics in final stage of production. Occurrence of numerous outbreaks as well as reduced financial and human resources prevented full achievement of target

Indicator	Baseline	Target	Achievement
Number of targeted countries integrating WHO guidelines for surveillance and control of communicable diseases into their health care systems	No country had implemented integrated disease surveillance in its health care system	Implementation of integrated disease surveillance in 50% of countries in WHO African Region	Integrated disease surveillance implemented in 6 countries; 9 countries started implementing plans of action and 7 developed plans. Several training courses (on 8 different surveillance topics) conducted in various countries to strengthen surveillance capacity

Mechanisms established to increase the sustained availability of the human resources, reagents, pharmaceuticals and equipment essential for rapid detection, definition and containment of threats to public health from communicable diseases, zoonoses and drug resistance

Indicator	Baseline	Target	Achievement
Number of laboratories participating in programmes for laboratory strengthening and quality assurance	8 laboratories in African Region only	22 laboratories in African, European and Eastern Mediterranean Regions	20 laboratories in African, European and Eastern Mediterranean Regions
Number of targeted countries participating in Training in Epidemiology for Public Health Interventions	8 countries in African Region	22 countries in African, European and Eastern Mediterranean Regions	22 countries in African, European and Eastern Mediterranean Regions 2 countries in South-East Asia Region and 1 in Western Pacific Region

International Health Regulations revised in order to cover all international public health urgencies

Non-regulatory worded ("lay") draft completed and distributed to Member States

Indicator	Baseline	Target	Achievement
Number of subprojects of the International Health Regulations revision completed by partner countries or technical experts in time for inclusion in "lay" draft	0	7	7 subprojects completed Revised draft of the International Health Regulations revision proposals prepared for regional consultations, translated into six official languages of WHO and distributed to Member States[1] This revised draft is a stage beyond the "lay" draft

Critical impediments

The lack of adequate financial and human resources for working with all Member States – in particular, the lack of regular budget funds – impeded progress and meeting unplanned needs (e.g. those resulting from the SARS outbreak) delayed implementation of some activities.

Relevance and adequacy

Contributions proved to be relevant in achieving the Organization-wide expected results. Moreover, the SARS outbreak unexpectedly raised awareness of the issue of response to public health events of international concern and the unique role played by WHO.

[1] See document IGWG/IHR/Working paper/12.2003.

Budget adopted by the Health Assembly versus expenditure

The total programme budget for 2002-2003 was US$ 70 743 000 of which US$ 13 743 000 was in respect of the regular budget. The total amount for other sources was US$ 57 000 000. Total expenditure in 2002-2003 was 101.8% of the programme budget. This higher rate of expenditure resulted from the receipt of additional funds from other sources during the SARS outbreak in 2003.

Total programme budget versus expenditure and expenditure by office (US$ thousand)

Area of work – programme budget	**70 743**
Area of work – expenditure	**72 012**

Expenditure by office:

Headquarters	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
47 669	11 426	1 313	3 026	1 072	1 248	6 258

Lessons learnt

- The momentum generated by WHO's advocacy and technical support during the biennium needs to be used to help Member States to initiate or further implement national plans for integrated disease surveillance and response, thus making it possible to respond appropriately to outbreaks at the national level.
- Key stakeholders, including programme managers, health development partners and representatives from the district level need to be involved early in the implementation of integrated disease surveillance and response in order to encourage a sense of ownership.
- New donors with long-term interest in epidemic alert and response should be identified.
- There is a need to contribute more directly, including financially, to the global partnership set up to coordinate epidemic alert and response in order to underscore WHO's commitment among partners in this area.
- WHO's global network of regional and country offices should be used more effectively for epidemic alert and response.
- WHO's strategy for epidemic alert and response needs to be developed further and implemented in all countries with the active participation of offices at country, regional and global levels.
- WHO's administrative rules and regulations need to be designed to support rapid, flexible and efficient response to emergencies.
- Internal collaboration within headquarters and between headquarters and regional offices is a key to success. Roles and responsibilities at different levels should be clarified, particularly in the context of global emergencies. An Organization-wide plan for responding to major incidents could be drawn up to provide the necessary guidance.
- Results-based budgeting has proved useful for monitoring and evaluation and has stimulated exchange between headquarters and regional offices as well as between regional and country offices.

COMMUNICABLE DISEASE PREVENTION, ERADICATION AND CONTROL

WHO objective(s)

To create an environment in which Member States and their partners in the international community are better equipped – both technically and institutionally – to reduce death and disability through the control and, where appropriate, eradication or elimination, of selected communicable diseases

Summary of achievements

- Organization-wide expected results were, for the most part, achieved and the majority of the targets set for diseases were either met or exceeded. Funding in certain key areas, however, was low.
- More emphasis was put on strengthening communication and collaboration with the regions in order to maximize the use of diminishing resources, and greater synergies were achieved among headquarters, and regional and country offices.
- Improved community awareness made it possible to achieve or exceed targets in some regions, particularly for certain diseases. Periodic joint planning sessions involving headquarters, regional and country offices proved useful in various eradication and elimination programmes.
- There was improved advocacy at the political level in countries, helping to highlight the burden of certain diseases. This was useful in the mass drug-administration programmes.
- Although it was not part of the 2002-2003 expected results, the Integrated Management of Adult and Adolescent Illness was initiated to provide support for WHO's chronic case management initiative. Interim versions of four modules on the Integrated Management of Adult and Adolescent Illness were completed; the topics covered were: acute care, chronic HIV/AIDS care with antiretroviral therapy, general principles of good chronic care, and palliative care.

Illustration of achievements at country, regional or global levels

- Two thousand million people, or one third of the world's population, are infected with worms such as soil-transmitted helminths and schistosomiasis. Since 1996, WHO has been providing technical assistance to WFP for its school feeding programme in Nepal, using teachers to administer the necessary drugs; more than 250 000 school-age children have thus benefited from deworming. By 2002, the number of infected children had dropped by 80% and, following this success, the Ministry of Health added deworming to its standard preventive health package for pregnant women, 50% of whom were estimated to be anaemic. Other bilateral and multilateral agencies also participated in the deworming programme. The partnership between WHO and WFP, together with collaboration with other partners in Nepal demonstrated how, with a feasible strategy, cheap drugs and a belief in using existing infrastructures and teachers to deliver health-related services, a fledgling pilot study can grow into a fully functioning national programme, with WHO as the lead technical agency.
- WHO helped WFP to add deworming to its school feeding programmes in 30 countries worldwide – the latest launch taking place in Afghanistan. The Organization also gave support to a number of other partners in Partners for Parasite Control, other United Nations bodies and nongovernmental organizations.

Achievement of expected results

Evidence-based prevention, control or eradication strategies developed for use by disease-endemic countries, that focus on establishing the principles of communicable disease control, building up from small-scale initiatives (e.g. for intestinal parasites and schistosomiasis), and working in conflict zones and underserved areas (particularly in relation to dracunculiasis and leprosy), recognizing the different impact of the diseases on males and females

Indicator	Baseline	Target	Achievement
Number of countries where effective strategies are in use for the control, prevention and eradication of communicable diseases	Dracunculiasis:18 Lymphatic filariasis: 22	Dracunculiasis: 18 Lymphatic filariasis: 35	Dracunculiasis: 18 Lymphatic filariasis: 38

Indicator	Baseline	Target	Achievement
	Leprosy: 15 Schistosomiasis and intestinal parasites: 25 Buruli ulcer: 7	Leprosy: 15 Schistosomiasis and intestinal parasites: 45 Buruli ulcer: 14	Leprosy: 15 Schistosomiasis and intestinal parasites: 46 Buruli ulcer: 7 (but scaled up within these 7 countries)
Proportion of school-age children at risk of morbidity regularly treated for soil-transmitted helminth infections and schistosomes (75% coverage target for 2010)	2% (16.2 million of 800 million)	4% (32 million of 800 million)	4.5% (36 million of 800 million)

New technologies and tools identified, including for prevention and control of vector-borne diseases and Buruli ulcer

Indicator	Baseline	Target	Achievement
Number of new or improved prevention and control tools (including pesticides) and interventions made available	0	Schistosomiasis and intestinal parasites: 2 Vector control: 4	Schistosomiasis and intestinal parasites: 2 Vector control: 4
Proportion of targeted countries adopting WHO definitions and reporting systems for Buruli ulcer	3 (19%)	14 (88%)	7 (44%)

Consensus created and partnerships consolidated around diseases targeted for elimination and eradication; control of schistosomiasis, intestinal parasites and vector-borne diseases scaled up; increased resources raised for country-based control

Monitoring and evaluation of communicable disease control in Member States

Indicator	Baseline	Target	Achievement
Existence and suitability for countries of plans agreed by partners for supporting control and elimination activities	Dracunculiasis: 18 Leprosy: 15 Lymphatic filariasis: 33 Schistosomiasis and intestinal parasites: 25 Buruli ulcer: 7	Dracunculiasis: 18 Leprosy: 15 Lymphatic filariasis: 40 Schistosomiasis and intestinal parasites: 45 Buruli ulcer: 14	Dracunculiasis: 18 Leprosy: 15 Lymphatic filariasis: 35 Schistosomiasis and intestinal parasites: 46 Buruli ulcer: 7
Proportion of target countries implementing plans to eliminate leprosy and lymphatic filariasis and eradicate dracunculiasis	Dracunculiasis: 100% Leprosy: 100% Lymphatic filariasis: 50%	Dracunculiasis: 100% Leprosy: 100% Lymphatic filariasis: 100%	Dracunculiasis: 100% Leprosy: 100% Lymphatic filariasis: 100%

Effective surveillance strategies developed and implemented in those countries completing eradication of dracunculiasis and elimination of leprosy

Indicator	Baseline	Target	Achievement
Compliance with agreed standards of frequency and timeliness of transmission of data to WHO	Dracunculiasis: none Leprosy: none	Dracunculiasis:18 Leprosy: 15	Dracunculiasis:18 Leprosy: 15
Proportion of endemic countries reporting on time	Dracunculiasis: none Leprosy: none	Dracunculiasis: 18 Leprosy: 15	Dracunculiasis: 18 Leprosy: 15

Critical impediments

Lack of funds represented the most critical impediment to achieving the expected results. The Organization-wide expected results were – for the most part – achieved, in relation to the indicators and targets. However, much more could have been done to reduce overall morbidity and mortality had adequate funding been available. Headquarters made use of carry-over funds from 2000-2001 to cover part of the shortfall, but this slowed the implementation of certain activities planned for the fourth quarter of 2003.

Relevance and adequacy

The products delivered were adequate for achieving the Organization-wide expected results.

Budget adopted by the Health Assembly versus expenditure

Expenditure expressed in relation to the programme budget was 101.8%.

Total programme budget versus expenditure and expenditure by office (US$ thousand)

Area of work – programme budget	**141 911**
Area of work – expenditure	**144 526**

Expenditure by office:

Headquarters	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
85 972	41 884	6 086	5 731	57	1 819	2 977

Lessons learnt

- More resources need to be invested in resource mobilization at country, regional and global levels. Communication and collaboration with the regions need to be strengthened, especially for planning, monitoring and evaluation. In this way, implementation of the highest priority activities across WHO can be ensured, building upon and taking advantage of existing synergies between different disease programme areas in order to make the best use of the limited human and financial resources available both within the Organization and at country level.
- Headquarters and the regions agree that they need to work more closely on resource mobilization. Although the regions recognize that support should be given to countries in this area, they themselves lack the necessary human and financial resources. Headquarters also suffers from a lack of human resources at departmental level. More investment is needed to improve advocacy and resource mobilization.

- The assessment exercise for 2002-2003 underlined the need for better collaboration on the elaboration of Organization-wide expected results and indicators together with the office-specific contributions necessary for achieving those results.
- It is necessary to produce more precise Organization-wide indicators for 2004-2005 and a more accurate definition of priorities in headquarters operational plans for 2004-2005 in collaboration with regional counterparts.
- There is room for improvement in the way products are defined in relation to expected results as well as in the definition of expected results and indicators.

RESEARCH AND PRODUCT DEVELOPMENT FOR COMMUNICABLE DISEASES

WHO objective(s)

To stimulate partnerships and to create an environment for better use of existing tools for the prevention and control of infectious diseases; to generate new knowledge, tools, intervention methods and implementation strategies to be used by health systems in a gender-sensitive manner, particularly in developing countries; and to build up research capability in developing countries.

Summary of achievements

- More than 600 researchers and their groups throughout the world were engaged in this area of work by the WHO regional offices and the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases.
- Results achieved through work performed in concert with partners included the following: the registration of two new drugs (miltefosine for the treatment of visceral leishmaniasis, and "Lapdap" for the treatment of uncomplicated malaria); the incorporation of research findings obtained with Roll Back Malaria into a strategy for the home-based management of malaria; the elaboration and publication of a tool to help to detect if loiasis is prevalent in communities undergoing ivermectin distribution; the publication of the *Anopheles gambiae* genome sequence, which was a major contribution to research on the genomics of disease vectors; and the organization of international scientific working group meetings to identify global research priorities in leprosy and malaria for the coming five to 10 years.
- The WHO Special Programme web site became a major, internationally recognized source of information on tropical diseases and the mean monthly number of page views increased three-fold compared to the previous biennium.

Illustration of achievements at country, regional or global levels

- The Special Programme and the regional offices worked both individually and in collaboration to continue strengthening research capacity in disease-endemic countries; this effort involved providing training grants to promising young scientists as well as specific training and research opportunities to established scientists.
- Several projects for institutional strengthening were launched to complement those started in previous bienniums. As an example of their value, support from the Special Programme to the Universidad del Valle, Cali, Colombia, provided the opportunity to initiate an International Malaria Research Training Program which has attracted significant funding from other sources.

Achievement of expected results

New basic knowledge about biomedical, social, economic, health system, behavioural and gender determinants, and other factors of importance for effective prevention and control of infectious diseases, generated and accessible at national and international levels

Indicator	Baseline	Target	Achievement
Number of new, significant and relevant scientific advances (biomedical, social, economic, and public-health sciences) for control of neglected tropical diseases	379 publications indexed in MEDLINE (in the last biennium)	250	275

New and improved tools devised for prevention and control of infectious diseases, e.g. drugs, vaccines, diagnostics, epidemiological tools, environmental tools

Indicator	Baseline	Target	Achievement
Number of new candidates (drugs, vaccines and diagnostics) ready to enter into development	Not established	Not established	3

Indicator	Baseline	Target	Achievement
Number of new or/and improved tools (drugs, vaccines and diagnostics) receiving regulatory approval for controlling neglected tropical diseases	0 (in the last biennium)	3	2

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

Indicator	Baseline	Target	Achievement
Number of new or improved intervention methods validated for the prevention, diagnosis, treatment and rehabilitation of populations exposed to neglected tropical diseases	4 (in the last biennium)	2	2

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

Indicator	Baseline	Target	Achievement
Number of new or improved control policies and strategies for targeted neglected tropical diseases formulated, tested and validated	3 (in the last biennium)	2	1
Number of new and improved tools introduced in the control of neglected tropical diseases	3 (in the last biennium)	2	1

Partnerships established and adequate support provided for building up capacity for research and product development in countries

Indicator	Baseline	Target	Achievement
Proportion of experts and centres from disease-endemic countries engaged in research and product development; proportion of research findings produced	60% (experts and centres in the last biennium)	60%	65%
	35% (research fundings in the last biennium)	40%	60%

Adequate technical information, research guidelines and instruments, and advice accessible to partners and users in countries

Indicator	Baseline	Target	Achievement
Number of research and development initiatives for control of neglected tropical diseases using the instruments developed	Original baseline not appropriate	Original target not appropriate	Indicator could not be measured; new indicator substituted: "Number of research instruments and guidelines for infectious diseases developed and published"; 25 such products developed and published
Number of requests from developing countries for appropriate WHO web site pages	Original baseline not appropriate	Original target not appropriate	Indicator could not be measured; new indicator substituted: "Mean monthly number of page views to the WHO/TDR [Special Programme] web site"[1] Number of pages viewed: 155 121
Number of effective contacts with research and development partners working in control of neglected tropical diseases	Original baseline not appropriate	Original target not appropriate	Indicator could not be measured; new indicator substituted: "Number of unsolicited requests for research guidelines and instruments" 1956 e-mail and letter requests 185 041 web downloads of research guidelines and instruments

Resources for research, product development and capacity building efficiently mobilized and managed

Indicator	Baseline	Target	Achievement
Level of increase in funding overall and in contributions resulting from the participation of new groups of donors[2]	0% increase compared to previous biennium	56%	17%

Critical impediments

Internal: the increase in financial resources was smaller than expected and exclusively tied to designated funding. Undesignated funds continued to decline, making it more difficult to allocate resources efficiently, based on changing needs and implementation opportunities.

External: the environment in which the area of work operated became increasingly complex because of volatility in donor interests together with the emergence of various narrowly focused initiatives. As a result, there was a need for more resources to be allocated for resource mobilization, reporting and partnerships.

Internal and external: although there was welcome evidence during the biennium of increased international resources for health, these were primarily focused on short-term gains based on existing technologies and paradigms. Investment in use-inspired research to produce the next generation of communicable disease control tools and methods continued to fall behind.

Relevance and adequacy

In order to pursue the interests of the disease-endemic countries, a strong international presence continues to be relevant in relation to the following activities: strategic innovative research, product development and evaluation, research to establish appropriate intervention methodologies, and work on the optimization of all tools to facilitate access and the scaling-up of action to combat communicable diseases. Such a presence ensures that developing country interests and research capacity building become integral to the above activities and that the fruits of research are integrated into disease control for poor and marginalized populations.

[1] Accessible online at the following address: http://www.who.int/tdr.

[2] The increase in funding relates exclusively to new groups of private contributors.

The lead time in this area of work from initial investment in an activity until the moment results are provided ranges from three to 10 years. Therefore, the achievements flowing from funding secured in 2002-2003 and the shift to results-based planning and management will only become apparent in 2004-2005 and 2006-2007 if funding levels are sustained.

Budget adopted by the Health Assembly versus expenditure

Expenditure as a percentage of the programme budget was 75%. The difference between the programme budget and expenditure was largely the result of a shortage of funds and the transition from input-based to results-based planning and management, together with a growing interest in using legal partnerships to cover some designated resourcing.

Total programme budget versus expenditure and expenditure by office (US$ thousand)

Area of work – programme budget	**88 876**
Area of work – expenditure	**66 696**

Expenditure by office:

Headquarters	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
65 188	300	946	Not applicable	Not applicable	160	102

Note: Research and product development for communicable diseases largely operates through a trust fund for the Special Programme. The fund is held at headquarters with the majority of operations occurring at country level.

Lessons learnt

- The shift to results-based planning and management allows for increased efficiency and relevance of outputs. However, the conceptual shift away from input-based approaches requires not only a shift in thinking and work practices, but also the development of new managerial tools and skills.
- More effort is required before research needs concerning the burden of communicable diseases affecting poor and marginalized populations can be met. Despite the increased number of organizations operating in the field and an increase in funding, many gaps persist.
- There is a large research capacity available in developing countries which is not being fully utilized. Failing to use and further enhance this capacity will eventually affect sustainability. In the longer term, it will also further exacerbate inefficiencies in international research and disease control systems.
- WHO is in a unique position to lead and facilitate research on new and improved approaches to controlling communicable diseases thanks to its expertise and its vast network of offices in regions and countries, together with its partnerships with UNICEF, UNDP, the World Bank and others through the Special Programme.

MALARIA

WHO objective(s)

To optimize the impact of the global partnership to Roll Back Malaria, and ensure the effectiveness of WHO and associated bodies in that partnership; to support and sustain regional, country and thematic partnerships to roll back malaria; to scale up effective action within countries; to build up capacity for up-to-date and consistent technical guidance; and to monitor progress by detecting the percentage reduction in the malaria-related death rate, and to evaluate achievements.

Summary of achievements

- The Global Fund to Fight AIDS, Tuberculosis and Malaria, established in 2002, included malaria largely thanks to advocacy undertaken by the Roll Back Malaria partnership. During the biennium, the Global Fund approved malaria control proposals from 60 countries, totalling US$ 942 000 000 over five years.
- The first Africa malaria report was produced in cooperation with UNICEF in 2003,[1] and a global malaria database was developed for the Web.
- Antimalarial resistance and drug policy networks were consolidated and expanded in Africa, Asia and South America. Nineteen countries adopted artemisinin-based combination therapy as first- or second-line treatment for falciparum malaria, increasing the total to 26.
- Consensus on strategic frameworks for scaling up insecticide-treated nets and prevention and control of malaria in pregnancy was achieved among partners.
- Roll Back Malaria partnership governance and management mechanisms were made operational.

Illustration of achievements at country, regional or global levels

- A composite 2004-2009 Roll Back Malaria department strategic framework with clear goals and indicators was developed with regional inputs.
- An average of 70% to 80% of endemic countries receiving WHO technical support to elaborate and submit proposals to the Global Fund were successful during the first three rounds.
- The Monitoring and Evaluation Reference Group was established (chaired by WHO and UNICEF) to provide guidance on improved monitoring and evaluation systems.
- In the WHO African Region, campaigns for re-impregnation of nets were initiated in several countries; in Ghana and Zambia distribution of insecticide-treated nets was initiated together with measles immunization activities.
- Home treatment of malaria cases was adopted in five countries in the African Region.
- A project for prequalification of artemisinin-based combination therapy was initiated.

Achievement of expected results

National authorities able to plan, implement, monitor and evaluate the impact of malaria control with support of the global Roll Back Malaria partnership

Indicator	Baseline	Target	Achievement
Proportion of targeted countries having a system of monitoring and evaluating action to roll back malaria	100%	100%	All countries had a system for monitoring and evaluation for malaria control. During the biennium, most countries improved these systems with WHO cooperation

[1] The Africa malaria report 2003 (document WHO/CDS/MAL/2003.1093).

Political commitment sustained and adequate resources mobilized through effective communication of the concept, strategy, approach and progress of Roll Back Malaria

Indicator	Baseline	Target	Achievement
Magnitude of the increase in overall resources available to Roll Back Malaria	Estimated at US$ 200 million per year	US$ 3 billion per year	Estimated increase of about US$ 200 million per year corresponding to Global Fund approval of US$ 942 million over a five-year period
Proportion of countries with an agreed national advocacy strategy for Roll Back Malaria	22 of 75 countries in the WHO African Region, WHO Region of the Americas and WHO European Region	59 of 75 countries in the African Region, Region of the Americas and the European Region	38 of 75 countries

Country-level partnerships established among national authorities, development partners and other groups to support malaria control

Indicator	Baseline	Target	Achievement
Proportion of targeted countries with functional partnership for Roll Back Malaria	33 of 102 countries in the 6 WHO regions	92 of 102 countries in the 6 regions	72 of 102 Global Fund recipient countries (coordination mechanism was condition for Global Fund approval)
Proportion of targeted countries that have prepared, with support of partners, evidence-based national plans for Roll Back Malaria	25 of 71 countries in the WHO African, South-East Asia, Eastern Mediterranean and Western Pacific Regions	66 of 71 countries in the African, South-East Asia, Eastern Mediterranean and Western Pacific Regions	53 of 71 countries in the African, South-East Asia, Eastern Mediterranean and Western Pacific Regions

Country capacity for operational research and evidence-based decision-making built up through provision of sound, consistent advice and technical guidance for malaria control

Indicator	Baseline	Target	Achievement
Number of technical support activities provided to countries and partners at global, regional, and country levels	Not established	Not established	About 600. Figure, partly based on data from regional offices and headquarters, partly on interpolations, included: technical meetings arranged by WHO, support missions to countries or to technical meetings arranged by others, and the number of international and national WHO staff in countries
Number of technical guidelines provided to countries and partnerships established for rolling back malaria	8	Not established	23 new technical guidelines were issued by headquarters and regional offices
Proportion of targeted countries having generated evidence-based strategies for rolling back malaria	2. Cambodia: rapid diagnostic tests and artemisinin-based combination therapy; Ethiopia: home-based management	Not established	9 in Africa: national impregnation days, combining insecticide-treated nets with immunization, packaged nets and treatment kits

New or modified interventions and products to roll back malaria validated through applied research

Indicator	Baseline	Target	Achievement
Number of new tools and modified interventions validated through applied research	2 (artemisinin-based combination therapy, home-based treatment)	1	2 (long-lasting insecticide-treated nets evaluated with interim recommendation; malaria early warning systems for epidemics)
Percentage increase in the global investment in research and development for rolling back malaria	Estimated at 100-200 million	Not established	Current annual investment in malaria research and development estimated at over US$ 300 million

Strategies promoted for scaling up action to roll back malaria, including selected interventions, policy, management and delivery systems, financing, and social action

Indicator	Baseline	Target	Achievement
Proportion of targeted countries with clearly set strategies, including benchmarks, for scaling up home management (rapid diagnosis and prompt treatment) of malaria	1 of 47 (Viet Nam)	10 of 47 (WHO Regional Office for Africa; Viet Nam)	6 of 47 (Regional Office for Africa; Viet Nam)
Proportion of targeted countries with clearly set strategies, including benchmarks, for scaling up use of impregnated bednets among targeted groups	15 of 84 (all regions)	38 of 84	32 of 84
Proportion of targeted countries with clearly set strategies, including benchmarks, for strengthening prevention among pregnant women and treatment of those with malaria	1 (Malawi)	5 of 44 (WHO Regional Office for Africa)	9 of 44 (Regional Office for Africa)

Critical impediments

Internal: in January 2003, the Roll Back Malaria project was split into two: Malaria control and the Roll Back Malaria partnership secretariat. However, in July 2003, the above were combined into the Roll Back Malaria department which now comprises two functional areas: the teams responsible for WHO's work in support of malaria control at the headquarters level, and the Roll Back Malaria partnership secretariat. Establishing a fully functional structure required both time and effort and once the Global Fund had been set up, the need to support countries for the development and implementation of their proposals created additional work that had to be carried out by WHO without additional resources.

External: despite the establishment of the Global Fund, there were some signs of "partner fatigue". Factors like complex emergencies and the trade in fake drugs worsened the problems posed by malaria in many countries. Partners expressed the need to increase efforts on dissemination, communication and advocacy for malaria.

Internal and external: considerable staff time and resources were spent on the external evaluation of Roll Back Malaria, the ensuing discussions and the restructuring of the programme.

Relevance and adequacy

The contribution of the Roll Back Malaria department was relevant in relation to all the expected results and indicators of the plan. However, owing to the impediments noted above, implementation of workplans was not optimal.

Budget adopted by the Health Assembly versus expenditure

Expenditure expressed against the programme budget shows a rate of 75.3%. This is considered excellent given that 90% of the budget is funded through voluntary contributions, some of which were earmarked for staff salaries and implementation of activities during the first half of 2004.

Total programme budget versus expenditure and expenditure by office (US$ thousand)

Area of work – programme budget	**118 212**
Area of work – expenditure	**89 006**

Expenditure by office:

Headquarters	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
28 700	39 528	1 629	4 186	1 497	7 208	6 258

Lessons learnt

- It is important to distinguish between technical and partnership work.
- A focus on a few, well-defined outcomes at country level is the best basis for effective Organization-wide work.
- A strong WHO presence at country level with a mix of national and international staff is crucial to success.
- Insecticide-treated nets need to be considered a public good.
- Implementation of artemisinin-based combination therapy requires greater private sector involvement.

TUBERCULOSIS

WHO objective(s)

To optimize the impact of the global partnership to Stop Tuberculosis by focusing on increasing technical support to countries' efforts to stop tuberculosis; to lead the global surveillance, monitoring and evaluation of efforts; to coordinate development of specific interventions, strategies and policies; and to promote, and act as a catalyst for, research into new diagnostics, drugs and vaccines.

Summary of achievements

- Substantial progress in expanding the strategy of directly observed treatment, short course (DOTS) was noted in all regions. The number of countries implementing the DOTS strategy increased by 25 during 2002-2003, bringing the total to 180 out of 210. By the end of 2002, 69% of the world's population lived in countries where DOTS was provided.
- The global, smear-positive case detection rate was 37% in 2002, more than half way to the 70% target, and increasing more rapidly than at any time since 1995. The success rate increased to 82%, close to the 2005 target of 85%. By the end of 2002, 18 countries had reached the targets for case detection and cure.
- Monitoring and evaluation, including assessment of national and global incidence and national programme performance, were carried out and the annual WHO reports on global tuberculosis control were issued for 2002 and 2003,[1] covering progress in control strategies and providing epidemiological, planning and financial data.
- Constraints on DOTS expansion were identified and technical assistance was provided to countries in coordination with partner organizations. Advocacy was also undertaken to increase governments' commitment to and assistance in mobilizing financial resources for countries.
- Several initiatives were developed and implemented in countries, including public/private mix, public/public mix, community tuberculosis care, tuberculosis/HIV collaborative activities, DOTS-Plus for multidrug-resistant tuberculosis and the Practical Approach to Lung Health; policies and guidelines were developed and distributed, including the interim policy on collaborative TB/HIV activities.[2]
- Quality assured anti-tuberculosis drugs were provided through the Global TB Drug Facility of the Stop TB Partnership. By the end of 2003, 58 applications had been approved for regular support, 15 for emergency support and two were pending. Drugs were delivered to 52 applicants, increasing the number of patients treated in these countries to 2.3 million. A direct procurement service was established and was soon being used by 11 countries.
- Access to second-line drugs for multidrug-resistant tuberculosis was further expanded through the multi-agency Green Light Committee, hosted by WHO. The Green Light Committee achieved a 95% reduction of prices following negotiations with the pharmaceutical industry. By the end of 2003, 15 DOTS-Plus pilot projects had been implemented in 12 countries, covering more than 4000 patients with multidrug-resistant tuberculosis. In recognition of its key role, the Global Fund to Fight AIDS, Tuberculosis and Malaria designated the Green Light Committee as the review, procurement and monitoring body for all country requests for second-line drugs made to the Global Fund.
- Partnerships at the global, regional and country levels were strengthened and a network on poverty and tuberculosis was set up to further mobilize civil society.

[1] Global tuberculosis control: surveillance, planning, financing: WHO report 2002 (document WHO/CDS/TB/2002.295); Global tuberculosis control: surveillance, planning, financing: WHO report 2003 (document WHO/CDS/TB/2003.316).

[2] Interim policy on collaborative TB/HIV activities (document WHO/HTM/TB/2004.330 or WHO/HTM/HIV/2004.1).

Illustration of achievements at country, regional or global levels

- In the WHO European Region, the Regional Committee adopted a resolution during its fifty-second session, endorsing the DOTS Expansion Plan to Stop TB in the WHO European Region 2002-2006 (resolution EUR/RC52/R8).
- The Western Pacific Region expanded DOTS coverage to 77%, with the cure rate exceeding the target. The case detection rate was 39%.
- In the South-East Asia Region, India led the way with more than a quarter of all additional DOTS cases benefiting from treatment. By the end of 2003, DOTS had been expanded to cover more than 778 million people, achieving a case detection rate of 72% in areas with DOTS coverage and a treatment success rate of 85%.

Achievement of expected results

Global- and national-level partnership established, underpinned by a framework of action (the global DOTS expansion plan) comprising shared goals and values, and expanded plans of action to reach national targets

Indicator	Baseline	Target	Achievement
Proportion of targeted countries with plans for DOTS expansion in order to reach national targets	16 of 22 countries	22 countries	100%. All 22 high-burden countries had formulated an overall plan for DOTS expansion by the end of 2003
Proportion of targeted countries with national partnerships established to stop tuberculosis	2 countries	22 countries	82%. 18 countries established a national partnership; the others were in an advanced stage of preparation

Stop tuberculosis fund established and operational to support a global facility for tuberculosis drugs that will expand access to treatment and cure

Indicator	Baseline	Target	Achievement
Proportion of eligible countries benefiting from the global drug facility	Beginning of 2002 Applied: 28 countries Approved: 12 Delivered: 3	Number depended on applications received, countries approved and resources available	Number of countries and nongovernmental organizations approved for support from the Global TB Drug Facility increased to 58 applicants and 49 countries. In the area of procurement, 40 countries received anti-tuberculosis drugs with another 9 scheduled for delivery for early 2004

New frameworks and tools to support increased national capacity for advocacy, social mobilization and programme management validated, made available and promoted

Indicator	Baseline	Target	Achievement
Number of countries using WHO tools for advocacy, social mobilization and programme management	0 countries implementing World TB Day activities according to WHO guidelines	50 countries	57 countries implemented World TB Day activities (114%)
	By the end of 2001, 75 partner organizations supported WHO targets	250 partner organizations to support WHO targets	By the end of 2003, 278 organizations had become members of the partnership and supported the global targets (111%)

Global surveillance and evaluation systems established for monitoring and evaluating: progress towards global targets, specific resource allocations for tuberculosis control, and impact of control efforts

Indicator	Baseline	Target	Achievement
Timeliness and accuracy of surveillance and evaluation information generated and reported to WHO	187 countries	210 countries	201 (96%) countries and territories reported case notifications for 2002 and/or treatment outcomes for patients registered in 2001. Reports from all 22 high-burden countries received
Proportion of targeted countries evaluating the impact of tuberculosis control	1 country	No target set because methods of evaluation under development	2 countries evaluated the impact of tuberculosis control

New policies and strategies developed to improve implementation of DOTS and to tackle HIV/tuberculosis, multidrug-resistant tuberculosis, participation of community and private practitioners, and integrated care at peripheral level

Indicator	Baseline	Target	Achievement
Proportion of targeted countries implementing pilot projects for combating multidrug-resistant tuberculosis, new policies for tackling HIV/tuberculosis, for determining mix of public/private care, and for assuring adult lung health	Multidrug-resistant tuberculosis: 3 countries	Multidrug-resistant tuberculosis: 15 countries	Multidrug-resistant tuberculosis: 15 DOTS-Plus projects in 12 countries (80%)
	Tuberculosis/HIV: 0 countries	Tuberculosis/HIV: 8 countries	Tuberculosis/HIV: 5 of 8 target countries implementing pilot projects for new policies for tackling tuberculosis/HIV (63%). An additional 8 countries are piloting tuberculosis/HIV activities
	Community tuberculosis care: 4 countries	Community tuberculosis care: 7 countries	Community tuberculosis care activities in 7 countries (100%)
	Public/private mix: 4 countries	Public/private mix: 10 countries	6 additional countries had pilot public/private mix projects by the end of 2003 (100%)
	Practical Approach to Lung Health: 1 country	Practical Approach to Lung Health: 10 countries	12 countries (120%) began activities relating to the Practical Approach to Lung Health

New diagnostic tools devised and field-tested, and a public-private partnership launched to accelerate development of new drugs

Indicator	Baseline	Target	Achievement
Access of countries to new diagnostic tools for tuberculosis	Smear microscopy: an antiquated tool (over 100 years old) Inadequate knowledge of global availability of existing technologies for tuberculosis diagnosis and laboratory infrastructure Lack of understanding between tool developers and control programmes Inadequate supply of clinical reference materials to support test evaluation	Fund applications to improve smear microscopy Creation of inventory of tuberculosis laboratory services in WHO Member States; evidence-based specifications for new diagnostic tools that meet medical need Launch of new foundation dedicated to accelerating tuberculosis diagnostic development; coordination of public and private partners Expansion of WHO tuberculosis specimen bank collection sites; establishment of tuberculosis strain bank	The Foundation for Innovative New Diagnostics launched in May 2003; 5 proposals funded to improve sputum microscopy through the diagnostics research and development steering committee of the UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases; inventory of tuberculosis laboratory services established for 108 countries worldwide; specimen bank sites shortlisted for review; source of strains and centralized facility for strain bank identified
Operation of a public/private partnership for development of new tuberculosis drugs	Not established	Not established	Unable to report against this indicator

Critical impediments

Internal: during the biennium, there was a continuing need for WHO to assist in mobilizing additional resources, especially unspecified funds, to assist technical support activities and capacity strengthening at country level. Several extrabudgetary contributions could only be used for specified activities and did not allow reallocation of funds for intensified country support. In addition, regular budget funding for tuberculosis was low compared with other areas of work such as malaria and HIV/AIDS. This was seen by some external partners as a sign of reduced commitment by the Organization to one of its main priorities and there was a risk that other sources of financing would be reduced as a result. Support provided to countries for activities in relation to the Global Fund to Fight AIDS, Tuberculosis and Malaria was also increasing even though only minimal additional funds towards these activities were available. Limited human resources at headquarters, and in regional and country offices were the main constraints operating on the timely and efficient implementation of activities, especially provision of intensified technical support, as donors were often reluctant to support WHO staff positions. Slow administrative processes in staff recruitment were also a major constraint.

External: the lack of qualified staff was considered to be the largest barrier to reaching the targets for case detection and cure. Recording and reporting remained weak in some countries. Inadequate basic infrastructure and weak primary health care systems further impeded national efforts to control tuberculosis. Poor laboratory quality control, the lack of a laboratory network, or limited access to laboratory services were additional impediments. Furthermore, private and public providers were not

sufficiently involved in the delivery of adequate care standards as promoted by the DOTS strategy; there was also limited commitment to, and capacity for, implementing DOTS in peripheral health services.

Relevance and adequacy

The contribution by headquarters and offices at regional and country levels was relevant towards achieving the expected results, but it needs to be intensified rapidly to overcome the constraints described above.

Budget adopted by the Health Assembly versus expenditure

One of the reasons for having unexpended funds was to establish the carry-over needed to cover staff salaries due in the first quarter of 2004. In addition, there were specified contributions, such as those for the Global TB Drug Facility or donations to the United States Agency for International Development, which are usually received towards the end of the biennium and for which implementation was foreseen for the beginning of 2004. Furthermore, certain contributions foreseen by WHO were eventually channelled through the trust fund of the Stop TB Partnership secretariat, housed at the World Bank. As a result, actual income did not reach the level envisaged in the Programme budget 2002-2003.

Factors beyond the Organization's control, such as the political situation in some targeted countries, were also responsible for delays in the implementation of funds for project activities at the regional and country levels. The outbreak of severe acute respiratory syndrome in the WHO Western Pacific Region in the first half of 2003, for example, had severe repercussions on many tuberculosis-related activities planned in countries in the Region.

Total programme budget versus expenditure and expenditure by office (US$ thousand)

Area of work – programme budget	**104 650**
Area of work – expenditure	**78 546**

Expenditure by office:

Headquarters	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
40 178	5 132	998	16 503	6 794	3 972	4 969

Lessons learnt

- A key factor for the successful provision of support to countries is coordinated action between headquarters, the regional and country offices, and partners and donors.
- Technical and managerial capacity building at country level is a priority. In order to scale up activities in countries, in-country WHO support must be sustained by making use of existing medical officers and increasing the number of national professional officers and national consultants. The timely availability of funds is also essential.
- There is a need to develop regional strategies for human resource capacity building at all levels, with an emphasis on strengthening management.
- Community involvement is essential for increasing accessibility, especially where health systems are weak.
- Partnership building at both country and regional levels is essential for mobilizing untapped resources for DOTS expansion and coordinating activities at regional and country levels.
- Close coordination with partners is critical. Housing the Stop TB Partnership secretariat within WHO has facilitated the development of strategies and policies. It has also supported the dissemination and implementation of policies through coordinated national strategic plans and harmonized donor assistance strategies and workplans for technical assistance and research.
- Support for social mobilization, and the development of collaborative approaches and initiatives for increasing access and case detection rates are essential. Advocacy at the level of national and local governments also needs to be supported to ensure the sustainability of national resources for tuberculosis control.

SURVEILLANCE, PREVENTION AND MANAGEMENT OF NONCOMMUNICABLE DISEASES

WHO objective(s)

To create an environment in which Member States and the international community are better equipped, technically and institutionally, to reduce people's exposure to the major determinants and risks associated with noncommunicable diseases; to assess the burden of these diseases and their complications and disabilities; to promote standards for health care for people with these diseases, and to ensure that health systems adapt to changing demands in a cost-effective way.

Summary of achievements

- During the biennium, the Global Forum on Integrated NCD Prevention and Control was successful in raising awareness, disseminating information, exchanging experiences and promoting global and regional networks.
- Guidelines were developed or updated for the four priority noncommunicable diseases (diabetes, chronic respiratory diseases, cancer and cardiovascular diseases); and more countries elaborated policies and programmes to combat them.
- The WHO Global NCD InfoBase reached the target of publishing the first report on the surveillance of risk factors related to noncommunicable diseases (*The SuRF report 1*)[1] together with the Global NCD InfoBase online tool.
- Community-based prevention programmes for noncommunicable diseases were in operation in all WHO regions, especially through the set of actions for the multifactorial reduction of noncommunicable diseases (CARMEN Initiative) in the Region of the Americas and the countrywide integrated noncommunicable diseases intervention (CINDI) in the European Region. A study protocol was also developed to measure the effectiveness of such community-based programmes.
- A comprehensive framework on innovative care for chronic conditions was developed and field tests began in four countries in four different regions.
- Eighty-two Member States were involved in networks of national programmes, demonstration projects or surveillance activities, including an increasing number of middle- and low-income countries.

Illustration of achievements at country, regional or global levels

- A global awareness campaign was launched in collaboration with the International Diabetes Federation.
- The WHO STEPwise approach to surveillance of risk factors for noncommunicable disease was implemented and participants from 48 Member States received training.
- A WHO draft global strategy on diet, physical activity and health was formulated.[2]

[1] *The SuRF report 1. Surveillance of risk factors related to noncommunicable disease: current status of global data.* Geneva, World Health Organization, 2003.

[2] Subsequently adopted by the Fifty-seventh World Health Assembly (see resolution WHA57.17).

Achievement of expected results

A global alliance established for prevention and management of noncommunicable diseases in order to strengthen advocacy, capacity building, and resource mobilization

Indicator	Baseline	Target	Achievement
Coordinating structure (and programme of work) in operation, involving organizations of the United Nations system, international institutions and nongovernmental organizations working in the area of noncommunicable diseases	1 broad network of community intervention projects in 2 WHO regions: CARMEN (Region of the Americas) and CINDI (European Region)	2 more regions with CINDI-type network	The Global Forum on Integrated NCD Prevention and Control successfully established and two meetings held (Beijing, 2002 and Rio de Janeiro, Brazil, 2003). Projects to establish new networks initiated and several now successfully completed. WHO regions concerned: African Region, 9 countries; South-East Asia Region, 6 countries (surveillance); Eastern Mediterranean Region, 9 countries; and Western Pacific Region, 14 countries (surveillance)

Comprehensive policy framed and strategic framework drawn up for prevention and management of priority noncommunicable diseases; strategies related to human genetics updated

Indicator	Baseline	Target	Achievement
Proportion of targeted countries with comprehensive national policies for prevention and control of noncommunicable diseases implemented with technical support from WHO	Only 20% of countries in the world have an organized policy framework for noncommunicable diseases	5 countries in each WHO region to organize a broad policy framework by the end of 2003	In the Eastern Mediterranean Region, 18 Member States involved in preparing national plans on hypertension prevention and risk factors in order to improve skills and knowledge in the epidemiology, prevention and control of cardiovascular disease. In the European Region, a draft regional strategy for prevention and control of noncommunicable disease elaborated. National policies, strategies and implementation plans for prevention and control of noncommunicable disease developed in the majority of countries in the South-East Asia Region. Establishment of regional networks and programmes for prevention and control of noncommunicable disease postponed in the Western Pacific Region following the epidemic of severe acute respiratory syndrome
Number of additional community-based demonstration programmes for control of noncommunicable diseases established in collaboration with WHO	Not established	Not established	4 new projects established in China, Indonesia, Islamic Republic of Iran and Oman

Simplified surveillance systems for the major noncommunicable diseases and their risk factors set up in order to measure effectiveness of prevention and management initiatives

Indicator	Baseline	Target	Achievement
Proportion of targeted countries adopting the WHO simplified surveillance system for the major noncommunicable diseases and their risk factors	4 countries in the WHO Western Pacific Region undertook training on the WHO STEPwise approach to surveillance of risk factors for noncommunicable diseases in July 2001	To implement the WHO STEPwise approach in 40 WHO Member States by the end of 2003	48 Member States adopted the WHO STEPwise approach. In addition, the WHO Global NCD InfoBase reached the target of publishing *The SuRF report 1* and the Global NCD InfoBase online tool.[1] 2 WHO regions (South-East Asia and Eastern Mediterranean) received training on InfoBase, which dramatically increased capacity at regional level

Evidence-based guidelines and standards of health care for the integrated management of major noncommunicable diseases and their complications validated and promoted, with special emphasis on equity between men and women

Indicator	Baseline	Target	Achievement
Number of priority noncommunicable diseases for which guidelines on cost-effectiveness of secondary and tertiary prevention interventions have been evaluated	Guidelines exist for 3 priority diseases: respiratory disease, cardiovascular disease and diabetes	Giving guidelines a more preventive orientation and performing regular updates	Clinical and preventive guidelines updated for the 4 priority noncommunicable diseases
Proportion of targeted countries integrating the guidelines for management of noncommunicable diseases into their health care systems	20% of countries are using guidelines for noncommunicable diseases	Double the number of countries using at least 2 guidelines for noncommunicable diseases in their health care systems	Focus on development, updating, evaluation and dissemination of guidelines increased. Despite a perception that use of existing guidelines for noncommunicable diseases increased, no formal assessment conducted to measure progress

Model, community-based, primary and secondary prevention programmes launched, linked by a global forum

Indicator	Baseline	Target	Achievement
Number of additional regional networks for noncommunicable diseases linked by a global forum	Not established	Not established	Regional networks for integrated prevention and control of noncommunicable diseases set up in 4 WHO regions (the African Region, the Region of the Americas, and the European and Eastern Mediterranean Regions); linked by the annual meetings of the Global Forum on Integrated NCD Prevention and Control

[1] Accessible at the following address: http://www.who.int/ncd_surveillance/infobase/en.

Indicator	Baseline	Target	Achievement
Number of countries participating in each regional network	Not established	Not established	Some 82 Member States involved in networks of national programmes, demonstration projects or surveillance activities with an increasing number from middle- and low-income countries as follows: African Region/Africa noncommunicable diseases network (NANDI), 9 countries; Region of the Americas/CARMEN network, 14 countries; South-East Asia Region, 6 countries (surveillance only); European Region/CINDI network, 30 countries; Eastern Mediterranean Region/Eastern Mediterranean approach to noncommunicable diseases network (EMAN), 9 countries; Western Pacific Region, 14 countries (surveillance only)
Proportion of targeted countries initiating model projects on integrated care and management of noncommunicable diseases	Not established	Not established	Model projects to scale up primary and secondary prevention of cardiovascular disease established in 28 low- and middle-income countries. 10 of these countries – from 5 WHO regions – completed assessment of gaps in health care in evidence-based secondary prevention of coronary heart disease and stroke; 5 launched context-specific interventions to narrow treatment gaps at local level. 15 countries from the 6 WHO regions began evaluating WHO cardiovascular disease-risk management package for integrated primary prevention of cardiovascular disease, in both demonstration projects and primary care settings

Capacity of health care systems built up in order to cope with the double burden of disease

Indicator	Baseline	Target	Achievement
Proportion of countries incorporating chronic care in health care reforms and initiating organizational change	Not established	Not established	Algeria, Islamic Republic of Iran, Jordan, Lebanon, Oman and Saudi Arabia expressed their commitment, implementing projects for the innovative care for chronic conditions with WHO support
Number of countries with demonstration projects on chronic care	Not established	Not established	A comprehensive framework on innovative care for chronic conditions developed in 2002; field tests began in Mexico, Morocco, the Russian Federation and Rwanda

Critical impediments

Internal: helping countries to develop national prevention and control programmes without adequate financial support was a major impediment. The lack of a critical mass of headquarters staff and continual changes in staffing delayed the finalization of documents.

External: the threats to health posed by noncommunicable diseases were not fully recognized by the parties concerned (stakeholders, nongovernmental organizations, decision- and policy-makers). The establishment of regional networks and regional programmes for prevention and control of noncommunicable diseases in the WHO Western Pacific Region was delayed by the epidemic of severe acute respiratory syndrome.

The main impediment to policy development was not the lack of evidence-based policies on noncommunicable diseases but rather insufficient awareness and capacity at country level. It proved difficult to discover effective processes for the integration and use of evidence-based guidelines within national health services.

Internal and external: financial investment and the prevailing health agenda did not accurately reflect the burden of noncommunicable diseases. Advocacy and resource mobilization remained inadequate despite the efforts made.

Relevance and adequacy

The global alliance and regional networks that were established were relevant but proved inadequate to support programmes for the prevention of noncommunicable diseases at regional and country levels. The comprehensive policy and strategic framework were well designed and targeted and enjoyed positive results during evaluations. All planned surveillance activities were both relevant and adequate for achieving the targets. The preparation and updating of evidence-based guidelines and standards were relevant for the provision of information about the changes required for implementation. However, implementation itself remained behind schedule.

Budget adopted by the Health Assembly versus expenditure

The additional expenditure of US$ 2 000 000 was secured from extrabudgetary sources, mostly to fund the preparation of the draft global strategy on diet, physical activity and health.

Total programme budget versus expenditure and expenditure by office (US$ thousand)

Area of work – programme budget	**20 029**
Area of work – expenditure	**22 031**

Expenditure by office:

Headquarters	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
14 303	2 794	789	426	1 036	1 403	1 280

Lessons learnt

- In cooperation with regional offices, the Global Forum on Integrated NCD Prevention and Control has played an important role in bringing together regional networks of national programmes for the prevention and control of noncommunicable diseases. Further efforts should focus on expanding the network through the inclusion of international nongovernmental organizations, professional organizations and other interested partners. Efforts should be pursued at all levels to foster active partnerships and the close coordination between headquarters, regional offices and countries, which was vital in setting up the Global Forum, needs to be further strengthened.
- It is imperative to develop a strategic plan with the regions and to further involve Regional Advisers in noncommunicable disease in activities to build capacity at regional office level and promote work that it has not been possible to pursue directly with the countries. Annual consultations among the three levels of the Organization are required to strengthen links and coordinate action.
- WHO is a key adapter of guidelines for less developed countries (in most cases, it is not feasible to implement developed country guidelines). Sufficient disease-specific guidelines are currently available and it is now necessary to develop integrated guidelines across all noncommunicable diseases. Furthermore, it is essential to focus on strengthening health systems for noncommunicable diseases rather than concentrating on guidelines for specific diseases.
- Awareness of the need to shift to chronic models of care needs to be raised.

- Results-based and adequate budgeting would allow for greater impact, particularly with a more adequate balance between planned and available resources.
- In addition, if the Organization's work at national level is to have a more positive impact, WHO programmes will need to be more closely aligned with long-term national, regional and global strategies and resolutions. WHO's support is crucial for fostering national consensus on policy and strategy for the prevention and control of noncommunicable diseases and for building networks of stakeholders. Technical staff involved in developmental work need more proactive assistance from activity support units in order to handle complex administrative tasks more effectively and make more time available for technical work. Strengthening links and promoting interaction between WHO staff at all organizational levels as well as building partnerships with global and regional stakeholders is essential for improving the implementation of technical programmes.
- Resource mobilization needs strengthening at regional and country levels.

TOBACCO

WHO objective(s)

To assure that governments, international agencies, and other partners are equipped effectively to implement national and transnational approaches to tobacco control.

Summary of achievements

- The WHO Framework Convention on Tobacco Control was unanimously adopted by the Organization's Member States in May 2003 – a landmark event in the history of WHO and global public health.
- Following the adoption of the treaty, subregional awareness workshops for the Framework Convention were held in WHO's African, European and Eastern Mediterranean Regions for a total of 22 countries.
- Over 130 countries were supported by WHO to run media and advocacy campaigns and more than 50 countries undertook World No Tobacco Day activities in 2002 and 2003, using information materials developed by the Tobacco Free Initiative.
- By the end of 2003, 112 countries had completed the Global Youth Tobacco Survey, a tool for monitoring tobacco consumption trends among 13- to 15-year-olds.
- Seed grants for national capacity building were disbursed to more than 30 countries and over 50 nongovernmental organizations were given similar grants for advocacy projects.
- Policy recommendations on tobacco and gender, regulation of tobacco products, and cessation of tobacco use were published, together with a guide on legislative capacity building.
- Three new projects were initiated under the auspices of the United Nations Ad Hoc Interagency Task Force on Tobacco Control.

Illustration of achievements at country, regional or global levels

- The WHO Region of the Americas' focus on smoke-free environments succeeded in encouraging several municipalities, states and public institutions to declare themselves smoke free in 2002-2003.
- In the European Region, the WHO European Ministerial Conference for a Tobacco-Free Europe (Warsaw, February 2002) strengthened political will among Member States of the Region.
- In the South-East Asia Region, India enacted comprehensive national anti-tobacco legislation.
- Newly developed or updated tobacco control legislation was passed in 16 Member States of the Western Pacific Region.
- Member States of the African Region rallied together and spoke with one voice during the negotiations on the framework convention.

Achievement of expected results

Increase in number of Member States with comprehensive tobacco control policies and national plans of action validated and promoted

Indicator	Baseline	Target	Achievement
Number of Member States with a national plan of action detailing deliverable tobacco control strategies and programmes	24	48	82 countries established national tobacco control committees and developed plans of action
Proportion of targeted Member States with comprehensive tobacco control policies framed and implemented	30%	45%	Reporting on this indicator not possible because baseline and target respected the 2000 edition of *Tobacco control country profiles*. The updated *Tobacco control country profiles (second edition)*, issued in July 2003, contains incompatible statistical categories

Consensus on multisectoral strategies in support of tobacco control reached among relevant bodies of the United Nations system, nongovernmental organizations, and private sector groups at regional and global levels

Indicator	Baseline	Target	Achievement
Number of best practices in tobacco control, initially focusing on interventions among young people and on economic aspects, adequately documented for use in countries, and taking account of gender considerations	0	20	15 best practice case studies published in 2002-2003, covering a range of topics
Number of new projects initiated under the umbrella of the United Nations Ad Hoc Interagency Task Force on Tobacco Control	2	6	3 new projects initiated in 2002-2003

Worldwide financial and human resources to control tobacco use substantially increased

Indicator	Baseline	Target	Achievement
Volume of human and financial resources directly applied to tobacco control by organizations of the United Nations system and by philanthropic organizations	US$ 15.3 million	US$ 21 million	Not possible to track figures; the World Bank continued to be the only United Nations agency apart from WHO to devote core resources to tobacco control

Improved surveillance in the areas of health, economics, legislation and behaviour in support of tobacco control

Indicator	Baseline	Target	Achievement
Number of countries having completed global surveys on tobacco use and related behaviour among young people, health professionals and health personnel	73	110	The Global Youth Tobacco Survey completed by 112 countries. Survey covering health professionals and health personnel not implemented owing to lack of funds
Number of countries covered by the joint WHO/Centers for Disease Control and Prevention Web-based tobacco information system	196	196	Not possible to track this indicator; information system discontinued (to be replaced by a global database)

Accelerated research on strategies for demand reduction and supply control in order to advance knowledge of effective responses

Indicator	Baseline	Target	Achievement
Volume of financial support provided by key partners for implementing agreed tobacco-control research agenda	US$ 8 million	US$ 10 million	Not possible to track figures; not achieved largely because of global economy and because research on tobacco not perceived as a priority by donors
Increase in the number of research projects consistent with the global tobacco-control research agenda and taking account of gender considerations	Not established	Not established	This indicator not tracked, although a regional situation analysis on women and tobacco completed in WHO South-East Asia Region

Enhanced global understanding of the tobacco epidemic and its consequences through stronger media coverage and information systems

Indicator	Baseline	Target	Achievement
Number of countries in which the anti-tobacco campaign, "Don't be duped", is in operation	48	111	Over 70 countries were supported to run "Don't be duped" and other media/advocacy campaigns
Web site providing detailed information on tobacco control resources in official languages of the United Nations system, in operation	Web site functioning	Web site bilingual (English/French)	Web site fully operational;[1] underwent a major renovation in 2003; many web pages translated into French

Framework convention on tobacco control and initial protocols prepared for adoption by Member States

Indicator	Baseline	Target	Achievement
Adoption of the framework convention on tobacco control by Member States and agreement on possible themes for protocols	First 3 rounds of negotiations held	Adoption of framework convention on tobacco control and suggestions on themes for initial protocols	Expected result achieved: Framework Convention on Tobacco Control unanimously adopted by WHO's Member States in May 2003

Critical impediments

The Tobacco Free Initiative received a smaller allocation of extrabudgetary funds than anticipated, which meant that many activities had to be cancelled or deferred. Many governments continued to commit only limited resources to tobacco control. Lack of capacity and the strong influence of the tobacco industry in many countries were also critical impediments.

Relevance and adequacy

Expected results were relevant and adequate, but achievements were hampered by a lack of funds.

Budget adopted by the Health Assembly versus expenditure

The programme budget was US$ 25 208 000 (US$ 5 708 000 in regular budget funds and US$ 19 500 000 from other sources). Total expenditure in 2002-2003 was US$ 22 927 000.

Total programme budget versus expenditure and expenditure by office (US$ thousand)

Area of work – programme budget	**25 208**
Area of work – expenditure	**22 927**

Expenditure by office:

Headquarters	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
13 296	1 988	1 273	1 218	2 268	935	1 949

[1] Information available online at the following address: http://who.int/tobacco.

Lessons learnt

- The importance of intersectoral collaboration is well recognized and the United Nations Ad Hoc Interagency Task Force on Tobacco Control will continue to be important for the work of the Tobacco Free Initiative in 2004-2005. However, there has been insufficient interagency collaboration at regional and country levels and the Task Force should ensure that a clear message on the importance of collaboration on tobacco control reaches the regional and country offices of the agencies concerned from their respective headquarters.
- Nongovernmental organizations are important facilitators of policy change. The process of bringing into existence and implementing the Framework Convention has highlighted the importance of balancing WHO's role as an intergovernmental organization with its relationship with civil society.
- The Tobacco Free Initiative needs to ensure that the link between tobacco and poverty is clearly understood by development agencies.
- The tobacco industry continues to wield a powerful influence and to undermine tobacco control activities in many countries. The Tobacco Free Initiative should continue close monitoring of tobacco industry activities and provide leadership and technical guidance to Member States.
- It is unrealistic in the short term to advocate for full and comprehensive tobacco control policies in all Member States. Instead, the Tobacco Free Initiative needs to devise strategies to identify entry points into governments' political agendas. During the next biennium, for example, the WHO Region of the Americas will be concentrating on smoke-free environments. This approach involves the community at large and could generate support for a broader tobacco control agenda.
- Intercountry and country workplans need to be better synchronized; closer collaboration between regional and country offices is thus required.
- The momentum created by the adoption of the Framework Convention must be maintained; the Tobacco Free Initiative now needs to concentrate its efforts in 2004-2005 on translating the treaty into reality at country level by building national capacity.
- Sustained national capacity-building efforts require greater resources and commitment. A sharper focus on country and local programmes and projects is also needed. More staff and resources at regional and country levels will be required to ensure the long-term success of WHO's tobacco control efforts. The Tobacco Free Initiative will also need to strengthen the evidence base at country level, including country-specific data, and achieve a better understanding of the economic burden of tobacco-related disease.
- Tobacco use is a major risk factor for noncommunicable diseases and should be given due priority in prevention programmes.

HEALTH PROMOTION

WHO objective(s)

To create an environment in which governments and their partners in the international community are better equipped to develop and implement multisectoral public policies for health and integrated gender- and age-sensitive approaches that facilitate community empowerment and action for health promotion, self-care and health protection throughout the life-cycle.

Summary of achievements

- The Global Programme on Health Promotion Effectiveness focused on developing countries and 25 projects in 15 resource-limited countries received technical and financial support.
- Two seminars were organized to build on the health promotion strategy for the African Region − one in Cotonou, Benin (for eight francophone countries) and one in Harare (for 11 anglophone countries).
- A major intercountry meeting, the Health Promotion Forum in the Americas, was held in Santiago in October 2002 as a follow-up to the Fifth Global Conference on Health Promotion (Mexico City, June 2000).
- The International Network of Health Promotion Foundations organized two meetings (held in Bangkok in 2002 and Budapest in 2003). Malaysia and South Africa initiated the process of establishing health promotion foundations; in November 2002, the network of the 11 most populous countries held meetings at which the importance of unhealthy diet, physical inactivity and tobacco use as major risk factors was highlighted.
- "Move for Health", emphasizing the importance of physical activity, was the theme of World Health Day 2002. Following the success of this initiative, promoting health through a "Move for Health Day" was taken up as the subject of a Health Assembly resolution and has become an annual event, organized in a large number of countries.[1]
- The United Nations Second World Assembly on Ageing (Madrid, April 2002) launched the International Plan of Action on Ageing, 2002 with a significant contribution from WHO.
- WHO, in collaboration with UNESCO, UNICEF and UNAIDS, launched the Global School-based Health Surveillance System, which relies on survey methods to monitor the prevalence of important health risk and protective factors among 13- to 15-year-old students.

Illustration of achievements at country, regional or global levels

- A resolution entitled "Health promotion: a strategy for the African Region" was adopted by the Regional Committee for Africa and guidelines were drawn up for its implementation.[2]
- The WHO Region of the Americas established three groupings of countries to develop health promotion, with particular emphasis on settings and healthy municipalities.
- The European Region established a centre for investment for health and development (based in Venice, Italy); the Region also has an active intercountry network.
- The South-East Asia Region held an interregional workshop on capacity building for health promotion.
- The Western Pacific Region published *The regional agenda for capacity building in health promotion 2002-2005*;[3] it also produced extensive support materials, including a catalogue on teaching and learning materials, together with a document on financing opportunities in the Western Pacific Region.[4]
- A number of countries, including South Africa and Sudan, also began developing national health promotion policies and strategies.

[1] See resolution WHA55.23.

[2] See resolution AFR/RC51/R4.

[3] *The regional agenda for capacity building in health promotion 2002-2005*. Manila, WHO Regional Office for the Western Pacific, 2003.

[4] *Health promotion financing opportunities in the Western Pacific Region*. Manila, WHO Regional Office for the Western Pacific, 2003.

Achievement of expected results

Appropriate guidance drawn up and furthered in order to design and implement multisectoral approaches in support of health promotion throughout the life-cycle, with special emphasis on the growing proportion of older men and women

Indicator	Baseline	Target	Achievement
Structures in operation for coordinating and supporting the multiple partners (intergovernmental organizations, nongovernmental organizations, academic institutions, private sector) that promote WHO recommendations on health for specific population groups	1 international nongovernmental organization (the International Union for Health Promotion and Education)	Health promotion networks in all regions to support national networks	International Network of Health Promotion Foundations, approval for Sixth Global Conference on Health Promotion (addressing a number of topics, including networking)
Proportion of targeted countries that have framed or updated multisectoral policies to prevent and control major risk factors of noncommunicable diseases and to tackle causes of health inequalities related to ethnicity, age, sex, income, or any other factor	Ad hoc group for health promotion (6 nongovernmental organizations) Regional networks and 3 subregional networks (WHO Region of the Americas)		

Appropriate guidance provided in order to prepare advocacy strategies and plans of action for increasing knowledge and awareness of the major determinants of health, and their different impact on men and women

Indicator	Baseline	Target	Achievement
Proportion of countries using WHO guidelines to advocate and implement actions that influence the major determinants of health	Not established	Regional health promotion strategies in 2 regions elaborated and agreed 1 pilot country project (South Africa)	Presently unknown, number of countries to be established through health promotion mapping; pilot project on capacity building in selected provinces in South Africa and a health promotion strategy for the African Region developed by the Regional Office for Africa

Community-based demonstration projects validated, including methods and tools for measuring process and outcome in vulnerable population groups, including older men and women

Indicator	Baseline	Target	Achievement
Number of community-based demonstration projects planned, implemented and evaluated in targeted countries	Not established	To strengthen networks, and exchange of information for addressing major factors and trends that affect global health	Currently unknown, number of countries to be established through health promotion mapping; the WHO Mega Country Health Promotion Network established, linking the 11 most populous countries; major focus on the following: 3 risk factors (unhealthy diet, physical inactivity and tobacco use), school health, surveillance and capacity building for health promotion

Activities to improve health literacy in targeted population groups identified and promoted

Indicator	Baseline	Target	Achievement
Number of targeted countries that adopt WHO recommendations for enabling marginalized and poor men, women and children to acquire the knowledge, attitudes, values, life skills and services they need to make sensible choices related to health	Not established	Not established	This expected result cancelled following major organizational restructuring. However, a report on health literacy published in *Health Promotion International*[1]

Selected studies conducted on health determinants; mechanisms in place for building up capacity to use findings to design and implement interventions that promote health

Indicator	Baseline	Target	Achievement
Networks and alliances to strengthen national and international action for health promotion in operation	Not established	Not established	This expected result also discontinued following organizational restructuring
Mechanisms for technical support and capacity building in planning and evaluating primary prevention and health promotion interventions in operation, including tools to analyse their different impact on men and women			

Critical impediments

Health promotion has not always been accorded priority, although a number of Health Assembly and Regional Committee resolutions have urged that this be done. During the biennium, this problem was exacerbated by a shortage of voluntary funding, which resulted in part from limited access to the donor community. Nevertheless, health promotion succeeded in attracting considerable extrabudgetary funding, most of which went to other important areas. The main impediment to the progress and success of health promotion arises from the current absence of a department of health promotion at headquarters, and its apparent downgrading in some regional offices, which does not send a positive message to countries or would-be donors.

Health promotion aims at influencing health policies, environments, behaviours and lifestyles through complex processes that enable people to improve their health behaviour and gain control over the determinants and conditions that affect health status and living conditions; however, it should not be confused with public health – a common error.

Relevance and adequacy

The organizational restructuring referred to above meant that the Programme budget 2002-2003 could not provide direction as originally intended.

Budget adopted by the Health Assembly versus expenditure

The difference between expenditure and the programme budget resulted from the late receipt of extrabudgetary funds, which remained unspent at year end.

[1] Kickbusch IS. Health literacy: a search for new categories. *Health Promotion International*, 2002, 17(1): 1-2.

Total programme budget versus expenditure and expenditure by office (US$ thousand)

Area of work – programme budget	**34 739**
Area of work – expenditure	**31 447**

Expenditure by office:

Headquarters	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
24 313	1 071	1 477	659	1 516	1 153	1 258

Lessons learnt

- The regional offices made a key contribution by providing leadership and both technical and, to a limited degree, financial support.
- Close collaboration between regional and country offices also proved to be crucial.
- The strong focus on building capacity at country level – either directly, or through networks – assists the Organization in its relations with Member States.
- Limited human and financial resources and changes in programme, direction, titles and responsibilities cause confusion, not least at country level.
- Consistency in programme direction, together with clarity in budget and staffing allocations are required in order to sustain efforts; maintaining consistency in structure and direction is essential for the Organization.
- Uncertainty about both regular and extrabudgetary resources, including projected budgets, makes it difficult to carry out forward planning.

DISABILITY/INJURY PREVENTION AND REHABILITATION

WHO objective(s)

To equip governments, and their partners in the international community, so that they can formulate and implement cost-effective, gender-specific strategies to prevent and mitigate the consequences of violence, unintentional injury and disability.

Summary of achievements

- In response to the growing concern about road traffic injuries, during the biennium WHO and the World Bank began drafting a report on road traffic injury prevention.[1] Technical assistance was also provided to several countries to strengthen data collection and prevention efforts and guidelines were developed to strengthen services for victims of injuries and violence.
- Community-based rehabilitation programmes were implemented in 90 countries. WHO conducted an impact assessment in Ghana, Guyana and Nepal in collaboration with the Swedish Organisations of Disabled Persons International Aid Association in order to learn how community-based rehabilitation programmes improve the quality of life of persons with disabilities. WHO, in collaboration with the Italian nongovernmental organization, Associazione Italiana Amici di Raoul Follereau, also organized the first international training course for 16 managers working in community-based rehabilitation.
- An international consultation on community-based rehabilitation was organized in Helsinki in 2003. The consultation encouraged community-based rehabilitation to focus on a stronger multisectoral approach, poverty reduction and community ownership. The report of the International Consultation to Review Community-Based Rehabilitation was launched on the International Day of Disabled Persons, 2003.[2] Six regional reports on country status in implementing the United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities – in so far as they related to health – were finalized and posted on the WHO web site.[3]
- Vision 2020, a global initiative for the elimination of avoidable blindness, was launched by WHO in partnership with international civil society organizations and the private sector. WHO played an important role in global planning and coordination, as requested by the Fifty-sixth World Health Assembly,[4] leading to the development of national plans of action. Technical cooperation with Member States included quality assessment of services and coordination of disease control activities for trachoma and onchocerciasis. The production of WHO's guidelines for hearing aids and services for developing countries led to the creation of a global initiative to provide affordable hearing aids in developing countries, coordinated by WHO.[5] A training resource on primary ear and hearing care, was also produced for incorporation into primary health care programmes.[6]

[1] Subsequently released on World Health Day 2004. *World report on road traffic injury prevention.* Geneva, World Health Organization, 2004.

[2] Report of International Consultation to Review Community-Based Rehabilitation (document WHO/DAR/03.2).

[3] Documents WHO/DAR/01.3-8. Accessible on the WHO web site at the following address: http://www.who.int/ncd/disability/publications.htm.

[4] See resolution WHA56.26.

[5] Guidelines for hearing aids and services for developing countries (document PBD/PDH/01.1).

[6] *Primary ear and hearing care training resource: intermediate level.* Geneva, World Health Organization (in press).

Illustration of achievements at country, regional or global levels

- In October 2002, WHO launched the first comprehensive global report on violence and health,[1] and with it, a global campaign for violence prevention. In addition, the Fifty-sixth World Health Assembly adopted a resolution on implementing the report's recommendations.[2]
- Policy documents on violence and health were adopted by the African Union, the United Nations Commission on Human Rights, the World Medical Association and the WHO Regional Committees for Africa and the Americas. WHO country and regional offices, as well as headquarters, collaborated to ensure that the report's recommendations were translated into concrete activities.
- In efforts that began in December 2003, more than 40 countries initiated activities which included the following: hosting national policy discussions, drawing up national plans of action for violence prevention and/or national reports on violence and health, and carrying out data collection for prevention programmes. Fifteen additional countries indicated they were developing national plans of action based on the report, which received extensive media coverage globally. The extensive regional- and country-level consultation process and collaboration were successful and the report and campaign confirmed the importance of the Organization's leadership in the field of violence prevention.

Achievement of expected results

Surveillance systems for major determinants, causes and outcomes of unintentional injuries and violence, including traffic accidents, validated and promoted

Indicator	Baseline	Target	Achievement
Proportion of countries that use WHO guidelines to collect data and training packages for monitoring trends	0	7 countries	7 countries

Appropriate guidance available for multisectoral interventions to promote safety and prevent violence

Indicator	Baseline	Target	Achievement
Proportion of targeted countries that have national plans and implementation mechanisms for prevention of violence and nonintentional injury	2 countries	5 countries	5 countries

Appropriate strategies existing in health systems for strengthening management of injuries and violence and their social and public health consequences

Indicator	Baseline	Target	Achievement
Proportion of targeted countries which incorporate training on management of violence and injuries into curriculum of medical and nursing schools	0	3 countries	Indicator not tracked. Initial focus on the following: developing a curriculum to enable schools of public health to teach injury and violence prevention; preparing guidelines for medico-legal services to victims of sexual violence[3]

[1] Krug EG et al., eds. *World report on violence and health*. Geneva, World Health Organization, 2002.

[2] See resolution WHA56.24.

[3] *Guidelines for medico-legal care for victims of sexual violence*. Geneva, World Health Organization, 2003.

Strategies validated for integrating rehabilitation services into primary heath care, including guidelines for early detection and management of disabilities in children

Indicator	Baseline	Target	Achievement
Proportion of countries implementing strategy for integrating rehabilitation services into primary health care, including the early detection of disabilities in children	65.5% among 84 countries where rehabilitation services exist at community level	120 countries to implement activities on community-based rehabilitation	Successful implementation by approximately 120 countries. In addition, several documents developed for strengthening national rehabilitation services, including a tool for early detection of disabilities in children,[1] which is being field-tested

Selected United Nations Standard Rules on persons with disabilities monitored globally; support provided for determining related advocacy positions or policy

Indicator	Baseline	Target	Achievement
Proportion of targeted countries that have (a) reported on implementation of selected United Nations Standard Rules and (b) determined an advocacy position or policy related to the Standard Rules	Questionnaires sent to 191 countries in relation to implementation of Rules 2, 3, 4 and 19	All countries implementing United Nations Standard Rules	Indicator not tracked. Report completed of governments' responses on the implementation of the four United Nations Standard Rules linked with health.
	115 replies received	All countries with policy related to Standard Rules	Report posted on WHO web site. Responses from governments and nongovernmental organizations
	81% implementation		

Strategies developed and validated for prevention and control of blindness, deafness and hearing impairment

Indicator	Baseline	Target	Achievement
Extent of application in countries of relevant WHO strategies	Extremely limited application of available strategies	Develop and launch the following strategies and guidelines:	
		Hearing aids/services	Hearing aids strategy completed and launched. Worldwide hearing global initiative and initiative for WHO South-East Asia Region set up
		Primary ear and hearing care	Training resource for primary ear and hearing care completed and piloted
		Elimination of blinding trachoma	Ultimate intervention goals for elimination of blinding trachoma determined for all countries in which disease endemic

[1] Rehabilitation for persons with traumatic brain injury (document WHO/DAR/01.9). A document entitled "The rehabilitation of people with amputations" is accessible online at http://www.einstein.edu/e3front.dll?durki=8104. An ILO/WHO/UNESCO document entitled, "Joint position paper on community-based rehabilitation: a strategy for rehabilitation, equalization of opportunities, poverty reduction and social inclusion of people with disabilities" is in preparation.

Indicator	Baseline	Target	Achievement
		Global framework for monitoring Vision 2020	Vision 2020 strategy formally adopted in 56 countries (African Region, 12; Region of the Americas, 11; South-East Asia Region, 8; European Region, 5; Eastern Mediterranean Region, 11; Western Pacific Region, 9) Indicators for global monitoring of Vision 2020 field-tested and finalized (database of country profiles in relation to selected indicators available soon on WHO web site)

Burden of visual and hearing impairment and programme implementation regularly monitored globally

Indicator	Baseline	Target	Achievement
Proportion of targeted countries documenting adequately the burden of visual and hearing impairments	No monitoring system available in the targeted countries Population-based surveys available in a limited number of countries	Update data on the global and regional burden of visual and hearing impairments	Global databank on blindness updated. Reliable data available for 68 countries WHO ear and hearing disorders survey protocol implemented in 10 countries[1] WHO rapid assessment of cataract surgical services package used in 11 countries[2]

Critical impediments

Internal: insufficient funding from the regular budget and lack of clarity regarding the rules for the distribution of extrabudgetary resources made it difficult to forecast financial resources.

External: disability prevention and rehabilitation in general and violence and injury prevention in particular were new to the public health field. As a result, there was a lack of awareness about the scale of the problem and the role of public health in prevention.

Relevance and adequacy

WHO's policy on disability prevention and rehabilitation, and its advocacy and technical products, enjoyed strong support and uptake among Member States, other members of the United Nations family, nongovernmental organizations and professional associations, thus confirming their relevance. In fact, country- and regional-level demand for WHO support and follow-up in implementing some of these policies and products threatened to exceed current Organizational capacity. This raises questions about the adequacy of achievements and of the funds available for country support and other follow-up activities.

[1] WHO ear and hearing disorders survey, protocol for a population-based survey of prevalence and causes of deafness and hearing impairment and other ear diseases (document WHO/PBD/PDH/99.8(1)).

[2] Cataract surgical services, a package for data entry and analysis form population-based rapid assessment (document WHO/PBL/01.84).

Budget adopted by the Health Assembly versus expenditure

Expenditure exceeded the programme budget because funds were mobilized from other sources beyond the amount initially projected. There is therefore a need for increased financial resources to be allocated to take account of the growing importance of this area of work.

Total programme budget versus expenditure and expenditure by office (US$ thousand)

Area of work – programme budget	**12 047**
Area of work – expenditure	**16 726**

Expenditure by office:

Headquarters	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
13 605	1 443	320	838	11	399	110

Lessons learnt

- Disability and rehabilitation involve a range of public health and social issues and this fact needs to be recognized.
- The commitment and expertise of staff and partnerships fostered both within and outside WHO are critical factors for success.
- Efforts must be made to strengthen expertise at headquarters and regional levels; networking and alliance-building between WHO and like-minded external partners must also be encouraged.
- Advocacy has been relatively successful in raising awareness about the public health dimension of violence and injuries; however, more must be done to ensure availability of resources in order to satisfy country requests for support in policy development and implementation.
- Difficulties were encountered in managing the area of work since the units concerned are spread across different departments. It has therefore been proposed that the unit dealing with disabilities and rehabilitation become part of the Department of injuries and violence prevention.
- Active partnerships should be pursued and nurtured at all levels. Close coordination between headquarters and regional offices, and between regional and country offices has been crucial to the successes achieved. In order to encourage close collaboration between the three levels of the Organization, the Department of injuries and violence prevention has initiated annual consultations among its headquarters and regional focal points. In addition, country-level involvement in the area of work is being increased by means of a global survey of country capacity to prevent injuries and violence.
- The area of work, particularly the field of injuries and violence prevention, is relatively new within international public health. Sustained efforts by WHO and its partners are required to cement its place on the international public health agenda and ensure close linkages and collaboration among agencies and within governments.

MENTAL HEALTH AND SUBSTANCE ABUSE

WHO objective(s)

To assure that governments and their partners in the international community place mental health and substance abuse on the health and development agenda in order to formulate and implement cost-effective responses to mental disorders and substance abuse.

Summary of achievements

- During the biennium, the WHO mental health Global Action Programme was initiated. The Programme's main achievements include raising awareness about mental, neurological and substance abuse disorders and providing Member States with a number of practical resources, namely: an information base for the formulation and implementation of policies and plans, instruments and guidelines for training health professionals in effective interventions (particularly at primary health care level) and training and information for health professionals in the area of alcohol and illicit drugs.
- Special emphasis was placed on specific problems such as suicidal behaviours, alcohol use, substance abuse in people with HIV/AIDS, and epilepsy. In addition to addressing these problems, the general approach was to influence policies, service organizations and, in some cases, contribute to the improvement of legislation.
- Global databases on mental health resources, suicide and alcohol were established to provide Member States with updated information.

Illustration of achievements at country, regional or global levels

- Key information was provided on mental health systems in 191 countries; the global alcohol database is the most comprehensive global information source on alcohol consumption and alcohol policies, the mental health policy and service organization modules were adopted by all regions and the Global Campaign Against Epilepsy, a joint initiative of the International League Against Epilepsy, the International Bureau for Epilepsy and WHO, established itself in all regions and has now been adopted in more than 60 countries.
- Work undertaken by the WHO Region of the Americas contributed to the implementation of innovative mental health policies in 12 countries of the Region (Barbados, Belize, Bolivia, Brazil, Chile, El Salvador, Guatemala, Mexico, Paraguay, Peru, Saint Lucia and Uruguay). The Regional Office for Africa provided intensive support to five countries in improving access to treatment for people with epilepsy (Kenya, Senegal, Togo, Uganda and Zimbabwe).
- Many countries developed local activities to improve mental health systems even in the face of difficult circumstances; in Albania, for example, improvements were made in service planning and organization, leading to the reorientation of mental health care away from large institutions towards community-based services.
- In the West Bank and Gaza Strip, substantial improvements in mental health policy were initiated in collaboration with the public sector, local nongovernmental organizations and major donors.

Achievement of expected results

Increased awareness of policy-makers, professionals and the general public about the importance of tackling mental and neurological disorders and substance abuse

Indicator	Baseline	Target	Achievement
Proportion of countries in each region which, in consultation with WHO, held significant awareness-raising events	Not established	31 countries	61 countries. Successes enjoyed by awareness-raising events led to an expansion of the target. Some countries in which these events held subsequently provided with technical assistance in policy formulation

Indicator	Baseline	Target	Achievement
			In many countries, awareness activities featured different mental health topics, including suicide prevention, alcohol abuse, epilepsy and prevention of substance abuse
Proportion of targeted countries in which at least one advocacy group was created	0	10 countries	19 countries. Many countries successfully applied experiences gained in setting up advocacy groups to create further groups with minimum inputs from WHO

Information base for formulating and implementing mental health and substance use policies and plans established and disseminated; use in countries supported through technical cooperation

Indicator	Baseline	Target	Achievement
Proportion of targeted countries in each region for which information or data have been adapted according to country needs	0	30 countries	27 countries. Many countries used information base provided by WHO for training courses or ad hoc missions
Proportion of targeted countries in each region showing evidence of use of the information base for preparation of policies and plans	0	20 countries	16 countries. During 2003, 8 technical guidance modules on key mental health themes distributed to mental health representatives in countries and adapted for use in training programmes, advocacy strategies and teaching in diploma and degree courses

Global and regional alcohol research and policy initiatives established and implemented

Indicator	Baseline	Target	Achievement
Proportion of targeted countries which adapted alcohol policy guidelines according to their needs	0	Global	WHO Secretariat chose to consolidate the global alcohol database, collecting global information on alcohol consumption and information on country policies in order to collaborate with Member States on country-focused ad hoc initiatives
Proportion of targeted countries which undertook research on alcohol-related topics in line with those promoted by WHO	0	52 countries	49 countries

Instruments, guidelines and training packages available for assessing effective interventions for mental, neurological and substance use disorders; their application in countries supported through technical cooperation

Indicator	Baseline	Target	Achievement
Proportion of targeted countries which have incorporated WHO's tools and materials for assessment and management of clinical situations and needs, and for staff development, into national health services	0	35 countries	35 countries. A variety of instruments and guidelines made available for tackling the 3 categories of problems covered by the area of work (mental and neurological disorders and substance abuse)

More reliable and valid epidemiological and resources data available in order more accurately to measure the burden attributable to mental, neurological and substance use disorders and to develop appropriate policies and programmes, including for prevention of these disorders

Indicator	Baseline	Target	Achievement
Number (and regional representation) of countries included in epidemiology and resources databases	0	All countries	Global database of WHO's study of mental health resources (the ATLAS project) and the suicide mortality databank widely adopted; many countries use them for planning purposes
Proportion of targeted countries showing evidence of use of these databases for developing policies and programmes, including for prevention of mental, neurological and substance use disorders	0	12 countries	12 countries. A more sophisticated monitoring system piloted successfully in 12 countries (and will be expanded in the next biennium)

Policy and technical support provided on the basis of evidence in order to assess and respond to HIV as related to substance abuse

Indicator	Baseline	Target	Achievement
Proportion of targeted countries involved in WHO international studies on determinants of substance use and related harm	0	18 countries	18 countries. Target successfully achieved by 2 large international studies: the WHO drug injection study and the WHO collaborative research project on drug dependence treatment and HIV/AIDS
Proportion of targeted countries better equipped to assess and respond to HIV-related substance abuse	0	20 countries	24 countries. Target exceeded thanks to an additional study on risky sexual behaviours associated with substance abuse, undertaken in 5 countries

Critical impediments

Internal: financial and human resources for mental health and substance abuse were not sufficient to deal with the broad spectrum of disorders and an increasing demand for support from Member States. Headquarters and the majority of Member States keep activities and programmes on mental health and substance abuse together; some regions, however, separate them and this is an obstacle to progress. Lastly, the high cost of translating relevant documents into official languages prevented some Member States from receiving important information.

External: in many countries, mental health is accorded only low priority, and consequently allocation of financial resources is poor, hindering improvement.

Internal and external: collaboration between the three levels of the Organization and national health authorities was in some cases less than optimal and prioritization was unsystematic as a result.

Relevance and adequacy

Country response and participation were positive – an indication of the relevance and adequacy of activities within this area of work.

Budget adopted by the Health Assembly versus expenditure

The difference between the programme budget and total expenditure was due to the shortfall in other sources throughout the biennium, resulting in a significant decrease in funds allocated to activities at global, regional and country levels.

Total programme budget versus expenditure and expenditure by office (US$ thousand)

Area of work – programme budget	**28 147**
Area of work – expenditure	**16 616**

Expenditure by office:

Headquarters	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
10 749	1 119	942	832	1 816	478	680

Lessons learnt

- Headquarters' and regional offices' responsibilities should be more clearly defined in order to increase the impact of normative and country activities.
- There is now sufficient accumulated evidence for interventions to begin a phase of intense implementation at country level. However, without timely implementation, the momentum created in the last few years will be lost.
- Translation and adaptation of materials are crucial for effective implementation at regional and country levels, however work on these activities has so far been insufficient.
- Alcohol, substance abuse and mental health in emergencies are issues of growing importance that the Organization needs to tackle.

CHILD AND ADOLESCENT HEALTH

WHO objective(s)

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

Summary of achievements

- A resolution on WHO's strategy on child and adolescent health and development was adopted by the Fifty-sixth World Health Assembly and work began on a framework to support countries in their efforts to develop policies based on the strategy.[1] In addition, the global strategy for infant and young-child feeding was endorsed by the Fifty-fifth World Health Assembly in 2002.[2]
- Implementation of the integrated management of childhood illness strategy reached the 100-country mark, with nearly half the countries in the expansion phase and one third covering more than 25% of districts.
- Research and development to improve child survival involved studies on a range of subjects, including the impact of zinc supplementation,[3] and interventions to achieve the following: improve neonatal survival,[4] reduce antimicrobial resistance,[5] improve infant feeding,[6] promote community management of pneumonia,[7] and improve teaching skills for teachers of medicine and nursing.[8]
- A strategy for addressing HIV among young people was developed; guidelines were also produced on making health services accessible to and relevant for adolescents, and on identifying risk and protective factors for healthy adolescent development.[9]

[1] See resolution WHA56.21.

[2] See resolution WHA55.25.

[3] Bhatnagar S et al. Zinc with oral rehydration therapy reduces stool output and duration of diarrhea in hospitalized children: a randomized controlled trial. *Journal of Pediatric Gastroenterology and Nutrition*, 2004, 38: 34-40; Abdullah Brooks W et al. Zinc for severe pneumonia in very young children: double-blind placebo-controlled trial. *The Lancet*, 2004, 363: 1683-1688.

[4] Jones G et al. and the Bellagio Child Survival Study Group. How many child deaths can we prevent this year? *The Lancet*, 2003, 362: 65-71; the Bellagio Child Survival Study Group. Knowledge into action for child survival. *The Lancet*, 2003, 362: 323-327.

[5] Pakistan Multicentre Amoxicillin Short-Course Therapy (MASCOT) pneumonia study group. Clinical efficacy of 3 days versus 5 days of oral amoxicillin for treatment of childhood pneumonia: a multicentre double-blind trial. *The Lancet,* 2002, 360: 835-841; Consultative meeting to review evidence and research priorities in the management of acute respiratory infections (ARI): Geneva, 29 September – 1 October 2003 (document WHO/FCH/CAH/04.2).

[6] Daelmans B, Martines J, Saadeh R. Conclusions of the Global Consultation on Complementary Feedings. In: Special Issue on a World Health Organization Expert Consultation on Complementary Feeding. *Food and Nutrition Bulletin*, 2003, 24(1): 126-129; Daelmans B, Saadeh R. Global initiatives to improve complementary feeding. *SCN News*, 2003, 27: 10-18.

[7] Evidence base for community management of pneumonia. Report from a WHO/UNICEF/Karolinska Institute meeting of experts, Stockholm, 11-12 June 2002 (document WHO/FCH/CAH/02.23).

[8] A reference manual entitled "Effective teaching: a guide for educating healthcare providers" has been produced in a field-test version.

[9] Adolescent friendly health services: an agenda for change (document WHO/FCH/CAH/02.14); Young people and HIV/AIDS: opportunity in crisis. This joint WHO/UNICEF/UNAIDS report is available online at http://www.who.int/pub/prev_care/youngpeople/en; Broadening the horizon: balancing protection and risk for adolescents (document WHO/FCH/CAH/01.20).

Illustration of achievements at country, regional or global levels

- Multi-site studies in Delhi, India and Zanzibar, United Republic of Tanzania, showed that zinc supplementation reduces the duration and severity of diarrhoeal episodes. These findings may prove as revolutionary as the benefits of vitamin A supplementation.
- Work began on translating the global strategy for infant and young-child feeding into national policies and action and regional and national meetings on this subject were held in all WHO regions.
- Mortality during the newborn period represents a significant proportion of overall child mortality. Recognizing this, countries in all six WHO regions adapted national guidelines on the integrated management of childhood illness to include care of the newborn in the first week of life. The European Region implemented its programme of promoting effective perinatal care in 12 countries, and the South-East Asia Region developed a regional strategy to improve newborn health.
- Evidence from 53 countries and territories demonstrated that adolescents enjoying positive relations with parents, and who feel attached to their school, are less likely to engage in health risk behaviours, including early sexual activity and substance abuse.
- Thirty-four countries in the African Region and nine in the South-East Asia Region included adolescent health and development in their plans of action.
- Countries in all six regions developed and tested alternative approaches to training health workers in integrated management of childhood illness; approaches taken included shorter courses, on-the-job training, and distance learning.
- Preliminary results of a multi-country evaluation (involving Bangladesh, Brazil, Peru, Uganda and the United Republic of Tanzania) showed that training on integrated management of childhood illness improves the performance of health workers and can decrease child mortality at no extra cost.

Achievement of expected results

Adequate technical and policy support provided to an increased number of countries to give effect to the health-related articles of the Convention on the Rights of the Child

Indicator	Baseline	Target	Achievement
Proportion of countries which have initiated implementation of child and adolescent health-related recommendations as a result of WHO support to the reporting process of the Convention on the Rights of the Child	No country had initiated implementation at the beginning of the biennium	15 countries from an estimated 50 to 55 countries reporting to the United Nations Committee on the Rights of the Child during the biennium	12 countries (verifying progress difficult as majority of countries concerned only just beginning to think about follow-up on concluding observations and recommendations of Convention)

Support provided for research that results in improved policies, strategies, norms and standards for protecting adolescents from disease and risk-taking behaviour

Indicator	Baseline	Target	Achievement
Number of research projects supported by WHO that resulted in development of strategic norms and standards applicable in developing countries for protecting adolescents from the major diseases and risk behaviours affecting this age group	10 research projects were supported in the last biennium	20 new research projects to start during the biennium	18 new research projects initiated with support of WHO

Guidelines, approaches and tools for better implementation of integrated management of childhood illness and monitoring of progress validated and promoted in priority countries

Indicator	Baseline	Target	Achievement
Proportion of countries with infant mortality rates of 40 per 1000 or higher which have incorporated integrated management of childhood illness as one of the strategies in their national child-health policy	40 countries at the beginning of the biennium	58 countries	Of 73 countries with infant mortality rates of 40 or more, 71 began implementing the integrated management of childhood illness (8: introduction; 31: early implementation; 32: expansion). 54 of these countries incorporated integrated management of childhood illness into their national health policy or plans
Proportion of countries implementing integrated management of childhood illness and using information on progress as the basis for replanning at national level	Not established	Not established	Nearly all countries that adopted integrated management of childhood illness used information on progress as a basis for replanning at the national level (about 90%)

Consensus reached on definition of global goals in raising healthy children and confident, competent adolescents, and contribution to their achievement

Indicator	Baseline	Target	Achievement
Agreement on global agenda for action for healthy children and adolescents, including gender issues, and framework for its implementation in countries	There was no global agenda, nor were their global targets for adolescent health and development	Global agenda and targets established	The WHO strategy for child and adolescent health and development was adopted by the Fifty-sixth World Health Assembly[1] Goals and targets agreed internationally at events such as the United Nations General Assembly special session on children International commitment to child and adolescent health was confirmed at the WHO/UNICEF Global Consultation on Child and Adolescent Health and Development (Stockholm, 2002)

Critical impediments

Internal: financial resources were lower than expected, particularly with regard to unspecified income; as a result, certain activities were deferred or cancelled, staff members were reduced and there was a significant decrease in funds allocated for regional and country activities.

External: most regional and country-level work, both for child and adolescent health and for the Convention on the Rights of the Child, depended on close collaboration among agencies and within governments; such collaboration was not entirely under WHO's control.

Relevance and adequacy

The relevance of the expected results increased following work to tackle neonatal mortality, which had not declined as rapidly as child mortality. The adequacy of the achievements is questionable, however, owing to the shortage of funds experienced during the biennium.

[1] See resolution WHA56.21.

Budget adopted by the Health Assembly versus expenditure

Expenditure as a percentage of the total programme budget (US$ 72 127 000) was 61.1%. The difference between the total programme budget and total expenditure was due to the shortage of extrabudgetary funds throughout the biennium. This led to a significant decrease in funds for regional and country-level activities, and for the research agenda. At the regional level, significant unmet needs were observed in the African and Eastern Mediterranean Regions.

Total programme budget versus expenditure and expenditure by office (US$ thousand)

Area of work – programme budget	**72 127**
Area of work – expenditure	**44 082**

Expenditure by office:

Headquarters	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
25 875	10 451	1 282	2 196	1 773	1 104	1 401

Lessons learnt

- Advocacy has been relatively successful in raising the profile of adolescent health and development; however, more needs to be done to increase the prominence of child survival on the public health agenda at both the national and international levels.
- The regional and headquarters workplans for 2004-2005 have been amended to include information, education and communication activities for making national governments aware of the potential impact of actions to promote child survival.
- There is a clear and urgent need for strategies to scale up country-level activities on both integrated management of childhood illness and adolescent health and development. The "community" and "health systems" components of integrated management of childhood illness should be given additional attention.
- With this concern in mind, a series of activities has been added to the 2004-2005 headquarters workplan to give support to the regions and countries in developing such strategies.
- Active partnerships should be pursued and nurtured at all levels. Close coordination between headquarters and regional offices, and between the regional offices and countries has been a crucial factor in the success of this area of work. In order to continue and enhance such collaboration, an intensive joint planning exercise was undertaken as part of the programme budget process for 2006-2007. In addition, a series of annual consultations among the three levels were included in headquarters operational plans for 2004-2005.
- Funds available to the department at headquarters and its expenditure should be monitored more closely.

RESEARCH AND PROGRAMME DEVELOPMENT IN REPRODUCTIVE HEALTH

WHO objective(s)

Through research and support, to contribute to a reduction in morbidity and mortality related to sexual and reproductive health, and to implementation of accessible, equitable and high-quality reproductive health services in countries.

Summary of achievements

- WHO successfully employed a number of means to make important advances in sexual and reproductive health: supporting research and research capacity building, developing evidence-based norms and tools, providing technical and policy support to countries, and contributing to the establishment of partnerships for sexual and reproductive health.
- Three new global initiatives were launched: a global collaborative project on basic and clinical research for the prevention and treatment of pre-eclampsia; the WHO global survey for monitoring maternal and perinatal health (which, upon completion, will have collected data from more than 400 000 deliveries in over 1000 facilities from 56 countries); and a new initiative on maternal and newborn health and poverty.
- A system for the continuous identification of research evidence was implemented to ensure that WHO's family planning guidance is created, and maintained, using the best available evidence. This system includes a continuous and comprehensive process of identifying, critically appraising, and synthesizing new evidence as it becomes available.
- A study to validate a new "policy action tool " was completed in 2003. The tool will help countries to identify − and deal with − barriers and gaps in the legal, policy and normative environment related to maternal and neonatal health and health services.
- A conceptual document was issued at the request of major international agencies seeking guidance for their institutional strategies in the area of maternal and perinatal nutrition;[1] a similar document on the future of maternal and perinatal health research was prepared for the 25th anniversary of the National Perinatal Epidemiology Unit in the United Kingdom.
- An updated global strategy was drafted for the prevention and control of sexually transmitted infections, reflecting recent evidence and experience – accumulated at national, regional and global levels – concerning the control of such infections and the resulting impact on the HIV epidemic.
- The document, *Safe abortion: technical and policy guidance for health systems*,[2] was released and distributed to ministries of health through WHO regional offices; it is currently being translated into French, Polish, Portuguese, Russian and Spanish.
- A systematic review of maternal morbidity and mortality for 1997-2003 was completed, involving the screening of more than 60 000 reports and the inclusion of nearly 2500.[3] Global, regional and subregional estimates of the proportions of births attended by skilled health personnel were updated, and the global maternal mortality estimates for 2000 released.[4]
- A database of the 17 reproductive health indicators shortlisted for global monitoring − providing information at the national, regional and global levels − was developed and published on the Organization's web site in early 2003.[5]

[1] The document is in the form of three articles in *The Journal of Nutrition*: Villar J et al. Nutritional interventions during pregnancy for the prevention or treatment of maternal morbidity and preterm delivery; an overview of randomized controlled trials. *J Nutr.,* 2003, 133:16065-16255; Merialdi M et al. Nutritional interventions during pregnancy for the prevention treatment of impaired fetal growth: an overview of randomized controlled trials. *J. Nutr.,* 2003, 133:16265-16315; Villar J et al. Characteristics of randomized controlled trials included in systematic reviews of nutritional interventions reporting maternal morbidity, mortality, preterm delivery, intrauterine growth restriction and small for gestational age and birth weight outcomes. *J. Nutr.,* 2003, 133:16325-16395.

[2] *Safe abortion: technical and policy guidance for health systems.* Geneva, World Health Organization, 2003.

[3] Gülmezoglu AM et al. WHO systematic review of maternal morbidity and mortality: the prevalence of severe acute maternal morbidity (near miss). *Reproductive Health,* 2004, 1:3. Accessible online at http://www.reproductive-health-journal.com/content/1/1/3.

[4] *Maternal mortality in 2000: estimates developed by WHO, UNICEF, UNFPA.* Geneva, World Health Organization, 2004.

[5] Available online at http://www.who.int/reproductive-health/global_monitoring/database.html.

Illustration of achievements at country, regional or global levels

- Four clinical guides for the management of pregnant women with HIV infection were produced;[1] technical support in this area was provided to Ethiopia, Kenya, Lesotho, Mozambique, Sao Tome and Principe, Swaziland, Uganda, Zambia and Zimbabwe.
- National workshops on ethics in reproductive health research were supported in Oman and Pakistan and an intercountry meeting on implementing best practices to improve reproductive health was organized in Egypt.
- Policy and legal changes to increase access to reproductive health services were introduced in collaboration with the following 10 countries of the WHO Region of the Americas: Argentina, Barbados, Bolivia, Brazil, Colombia, Guatemala, Jamaica, Peru, Trinidad and Tobago, and Uruguay.
- All 11 countries in the South-East Asia Region received a range of technical support for improving reproductive health services, adapted to suit their needs and situations. The activities undertaken involved: providing support to countries in updating or developing their reproductive health profile (Bangladesh, Bhutan, India, Indonesia, Myanmar, Nepal, Sri Lanka and Thailand); organizing a meeting for the South-East Asia and Western Pacific Regions, with representatives from 17 countries, in order to gather comments on the draft global reproductive health strategy; and organizing a workshop on the WHO reproductive health library in which six countries participated.
- WHO collaborated in analysing the results of a rapid reproductive health assessment in Kyrgyzstan and Tajikistan, and for the development and implementation of national screening programmes for cervical cancer in Kazakhstan, Kyrgyzstan and Republic of Moldova.

Achievement of expected results

Selected studies completed, providing evidence on key sociobehavioural, clinical, epidemiological and policy issues in reproductive health, with emphasis on fertility regulation, safe motherhood, and sexually transmitted infections, and on cross-cutting issues such as participation of women and men in reproductive health, and reproductive rights; use of findings promoted through appropriate strategies to disseminate information

Indicator	Baseline	Target	Achievement
Number of studies on high-priority reproductive health problems of developing countries completed, with results disseminated and plans made for incorporation into policy and technical guidelines, as appropriate	Not established	30 studies	45 studies, including 13 systematic reviews and 8 Cochrane Collaboration evidence-based reviews and protocols were completed and results reported in peer-reviewed journals, through presentations at meetings and publication of policy briefs. Research outcomes incorporated into relevant normative guidance documents, as appropriate, and into best practice publications and evidence-based workshops.

[1] Clinical guides for the management of pregnant women with HIV infection: voluntary counselling and testing (document WHO/RHR/01.23), antenatal care for HIV-infected women (document WHO/RHR/01.24), labour and delivery care for HIV-infected women (document WHO/RHR/01.25), post-pregnancy care for HIV-related women (document WHO/RHR/01.26).

Cost-effective interventions for improving reproductive health applied and validated through operational research in countries

Indicator	Baseline	Target	Achievement
Number of operations-research studies evaluating new or improved approaches to provision of reproductive health care completed, and findings disseminated	Not established	15 studies	37 studies completed evaluating new or improved approaches to provision of reproductive health services

Appropriate set of policy, technical and managerial guidelines and evidence-based standards for good-quality reproductive health care validated and disseminated

Indicator	Baseline	Target	Achievement
Availability of a strategy for the integrated management of pregnancy and childbirth	Not established	Made available	Achieved. A strategy completed for making pregnancy safer, including introducing the integrated management of pregnancy and childbirth in countries
Number of targeted countries in which the strategy for the integrated management of pregnancy and childbirth is introduced and adapted	Not established	20 countries	10 spotlight countries for making pregnancy safer, with at least 10 additional countries
Availability of guides on essential care practice for family planning and reproductive tract infections	Not established	Made available	Achieved. Guides produced on essential care practice for family planning, including the third edition of a review of medical eligibility criteria for contraceptive use.[1] Guides on reproductive tract infections completed for field testing
Number of targeted countries having started to apply the guides on essential care practice for family planning and reproductive tract infections	Not established	5 countries	At least 5 countries applied tools for reproductive tract and sexually transmitted infections; at least 7 countries applied family planning tools. Many other countries and organizations applying these tools without WHO support

Adequate support provided to priority countries for elaborating or updating, implementation, monitoring and evaluation of plans for strengthening access to and availability of good-quality reproductive health care

Indicator	Baseline	Target	Achievement
Number of countries receiving support for preparing and implementing plans to strengthen access to, and availability of, high-quality reproductive health care	Not established	25 countries	38 countries received support for preparing and implementing plans to strengthen access to, and availability of, high-quality reproductive health care
Number of countries receiving support that determine policies and programmes to strengthen reproductive health care	Not established	Not established	No precise details. However, is known that a large proportion of countries mentioned above incorporated this support into programmes

[1] *Medical eligibility criteria for contraceptive use,* 3rd ed. Geneva, World Health Organization, 2004, in press.

Adequate support provided to priority countries for adaptation and adoption of articles of existing legal instruments, conventions, and international consensus documents related to reproductive health and rights

Indicator	Baseline	Target	Achievement
Number of countries receiving support for incorporating rights-based approaches in reproductive health policies, programmes, or services	Not established	5 countries	5 countries received support (Brazil, Kazakhstan, Mozambique, Myanmar and Sudan)
Number of countries receiving support that incorporate rights-based approaches in reproductive health policies, programmes, or services	Not established	Not established	2 of the 5 countries (Mozambique and Kazakhstan) are applying a rights-based approach to reproductive health policies and programmes

Critical impediments

Internal: although reproductive health is a priority both globally and regionally, sufficient funds and human resources were not made available, preventing or delaying achievement of expected results.

There is no focal point for reproductive and women's health in many WHO country offices in priority countries. As a result, it is difficult for WHO to play a leading role in the provision of technical support to governments trying to achieve their reproductive health objectives. Rapid turnover of skilled personnel in countries also contributed to delays and setbacks in programme implementation.

External: in some cases, lower priority is afforded to reproductive health by governments, which often manage projects with other international agencies involving higher funding levels than those provided by WHO. Shortage of funds and skilled professionals at the local level is another barrier to the achievement of objectives. Furthermore, reproductive health is a sensitive and complex issue; political and cultural factors can hamper implementation. Finally, the development of reproductive health programmes is faced with major challenges in countries where the concept of integrated reproductive health care has only partially been put into practice.

Internal and external: poor collaboration among national research institutes, relevant governmental sectors, nongovernmental organizations, and among the researchers themselves in making practical use of the findings of research studies, poses a challenge to the utilization of reproductive and sexual health-related data in programme monitoring and evaluation.

Relevance and adequacy

Achievement of the expected results is deemed relevant and adequate as demonstrated by the continuously high level of demand from a growing number of governments and other partners for technical support for research on normative guidance materials, and their development, adaptation and introduction, and for policy formulation and programme development. The research and research capacity strengthening carried out by the Organization in sexual and reproductive health through the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction was commended in an external evaluation undertaken during the biennium.[1] However, the expected results framework did not adequately reflect key achievements in the Organization's work in a number of areas, namely, individual, family and community practices that are related to, and impact on, reproductive health; and the establishment of partnerships for reproductive health. Expected results will be included in the next planning cycle to address this gap.

[1] See External evaluation: 1990-2002 – executive summary (document WHO/RHR/HRP/03.14).

Budget adopted by the Health Assembly versus expenditure

Total expenditure, including the regular budget and other sources for 2002-2003, was US$ 53 903 000. The difference between the programme budget and recorded expenditure was due to a shortage of extrabudgetary funds, as total income only reached US$ 54 000 000. The shortfall of approximately US$ 13 000 000 meant that there was a significant decrease in funds allocated to activities at the global, regional and country levels; in particular, it affected implementation of the research agenda of the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction.

Total programme budget versus expenditure and expenditure by office (US$ thousand)

Area of work – programme budget	**67 252**
Area of work – expenditure	**53 903**

Expenditure by office:

Headquarters	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
42 881	4 395	626	1 269	354	706	3 672

Lessons learnt

- Despite severe funding shortages, the Organization sought to honour commitments to provide technical and policy support to Member States. Products and activities that could not be implemented because of funding shortages included research projects, activities related to national research-capacity strengthening together with normative and standard-setting activities.
- When a holistic approach to reproductive health is adopted, advocacy should be continued to further strengthen and develop national programmes. Addressing sexual health as an emerging priority in reproductive health programmes will call for integrated interventions by trained health providers and functioning referral systems, as well as a supportive legal, policy and regulatory environment.
- Research is regarded as a strategic priority for improving the performance of reproductive health programmes. However, closer collaboration among national research institutes, relevant governmental sectors, nongovernmental organizations and the researchers themselves, in making practical use of the findings of their studies, is essential to enable better utilization of reproductive health-related data in programme monitoring and evaluation.
- Several Member States are suffering the adverse effects of political instability, domestic conflicts, economic sanctions and recession. When coupled with decreasing financial resources, these problems pose a double burden that must be taken into consideration when planning for promoting public health, including reproductive health through the life-cycle.
- To succeed, it is essential for plans to be developed jointly by global, regional and country levels.

MAKING PREGNANCY SAFER

WHO objective(s)

To enable Member States and the international community effectively to translate the health-sector strategy, Making Pregnancy Safer, into plans of action based on cost-effective interventions for, and approaches to, good-quality maternal care.

Summary of achievements

- A global strategy for making pregnancy safer was developed in collaboration with regional offices as a key step towards the United Nations Millennium Development Goal of improving maternal health and the target of reducing the maternal mortality ratio by three quarters by 2015.
- Work began on developing regional strategy papers for making pregnancy safer. WHO's Regional Office for the Americas completed a strategic consensus document for maternal mortality reduction, and the Regional Office for Africa began developing a results-based road map for accelerating attainment of the Millennium Development Goals related to maternal and newborn health in Africa.
- With input from WHO, the Council of Europe developed a document recommending that all countries in the region implement the Making Pregnancy Safer strategy.
- The WHO Making Pregnancy Safer web site was established (accessible at http://www.who.int/reproductive-health/MNBH/index.htm).
- Seven tools in the WHO integrated management of pregnancy and childbirth series were finalized and translated.[1] Several of these tools have been used to revise national policies and standards of care.
- The Making Pregnancy Safer Initiative has increased its technical and policy support to enable countries to review their essential package of maternal and newborn health services, and define national standards for clinical care and related health systems requirements.
- Areas for closer collaboration and coordination with other United Nations organizations and partners at global, regional and country levels were identified. At the regional level, new partnerships were built with the World Bank, UNICEF, UNFPA, and the United States Agency for International Development, among others; joint advocacy efforts were also initiated to ensure that safe motherhood remains high on the health and development agenda.
- In order to promote evidence-based information for effective decision-making, estimates for maternal mortality in 2000 were developed and published by WHO, UNICEF and UNFPA and a database of key maternal and newborn health indicators shortlisted for global monitoring was published on the WHO web site.[2]

Illustration of achievements at country, regional or global levels

- During the 26th Pan American Sanitary Conference, all Member States in the WHO Region of the Americas adopted a resolution on maternal mortality reduction (see document resolution CSP26.R13).
- The advocacy model, "REDUCE", was developed by the Regional Office for Africa to increase regional awareness of maternal and newborn health issues. At the end of the period under consideration, Ethiopia, Mauritania, Mozambique, Nigeria and Uganda had adapted and implemented the model.
- Policy changes in Uzbekistan, undertaken with WHO support, included the establishment of a general legal framework for maternal and newborn health to substitute outdated laws that constituted a barrier to evidence-based care.

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[1] *Managing complications in pregnancy and childbirth: a guide for midwives and doctors.* Geneva, World Health Organization, in press; *Managing newborn problems: a guide for doctors, nurses, and midwives.* Geneva, World Health Organization, 2003; *Pregnancy, childbirth, postpartum and newborn care: a guide for essential practice.* Geneva, World Health Organization, 2003; *Kangaroo mother care: a practical guide.* Geneva, World Health Organization, 2003; Working with individuals, families and communities to improve maternal and newborn health (document WHO/FCH/RHR/03.11); Making pregnancy safer: global action for skilled attendants for pregnant women (document WHO/RHR/02.17); *Antenatal care in developing countries: promises, achievements and missed opportunities – an analysis of trends, levels and differentials, 1990-2001.* Geneva, World Health Organization, 2003.

[2] *Maternal mortality in 2000: estimates developed by WHO, UNICEF and UNFPA.* Geneva, World Health Organization, 2004. Database accessible at http://www.who.int/reproductive-health/global_monitoring/RHRxmls/RHRmainpage.htm.

- The Government of India, in collaboration with WHO, launched a "National Safe Motherhood Day" on 11 April 2003, providing crucial commitment to the safe motherhood agenda across the entire country.
- A database on operational research in maternal and newborn health was developed by the Regional Office for the Eastern Mediterranean, allowing for easy access to and exchange of relevant evidence between countries in the Region.
- Increased awareness of and attention to women's health and gender issues were emphasized by the Regional Office for the Western Pacific, including domestic violence in the Republic of Korea, and women's suicide and violence against pregnant women in China.

Achievement of expected results

Adequate support provided to countries for preparing and implementing coordinated plans to make pregnancy safer, including monitoring and evaluation

Indicator	Baseline	Target	Achievement
Number of countries receiving support, preparing and implementing plans to reduce maternal and perinatal mortality and morbidity	Not established	20	Technical support provided to 47 countries and at regional level in order to operationalize regional and national strategy for making pregnancy safer and reducing maternal morbidity and mortality
Number of countries receiving support that determine comprehensive policies and programmes for reduction of maternal and perinatal mortality and morbidity	Not established	20	Targets achieved in 25 countries. More support needed to ensure well coordinated and comprehensive maternal and newborn health policies and programmes

Appropriate evidence-based guidelines drawn up and tools devised for establishing or adapting national policy and standards for maternal and newborn care (including post-abortion care), family planning, induced abortion care (where abortion is not against the law) and for ensuring that these standards are properly implemented and regulatory measures to support these policies and standards are in place

Indicator	Baseline	Target	Achievement
Number of countries receiving support that adapt and adopt WHO-recommended evidence-based policies and standards for maternal and newborn care	0	20	Effective support provided for adapting and adopting WHO standards into national policies and clinical protocols in 30 countries. (1 set of key clinical guidelines finalized and translated into 8 languages.) Adoption of other tools for integrated management of pregnancy and childbirth will continue in the next biennium as soon as additional guidelines finalized and translated

Appropriate framework designed for developing and implementing home or family- and community-level messages and interventions that promote maternal and newborn health and fertility regulation

Indicator	Baseline	Target	Achievement
Number of countries receiving support for developing grass-roots interventions to promote maternal and newborn health and fertility regulation	0	5	3 regions developed regional frameworks to better support countries. 2 regions conducted regional workshops involving a total of 20 countries. A global strategy on working with individuals, families and communities to improve maternal and newborn health developed and translated into French and Spanish

Indicator	Baseline	Target	Achievement
Number of countries receiving support that have started to implement the interventions developed			Implementation of framework not possible mainly owing to insufficient funding

Critical impediments

Internal: sufficient funds and human resources were not available for this area of work, rendering impossible or delaying delivery of the expected results and adequate follow-up thereof. Focal points were needed for Making Pregnancy Safer programmes in WHO country offices, especially in priority countries and the regional offices needed additional staff. In addition, most WHO staff in Making Pregnancy Safer programmes were short-term professionals, a situation that threatens the stability and continuity of investments and projects. Without the necessary human resources, it is difficult for WHO to play its technical lead role and give support to governments in achieving maternal and newborn health goals and objectives.

External: the prevailing brain drain and high turnover of skilled professionals were critical impediments. The limited number of professionals with midwifery, obstetric and neonatal skills contributed to serious setbacks in programme implementation. Other external impediments included poverty and a lack of functioning health systems. In addition to a shortage of skilled attendants, there was a general lack of equipment, supplies and drugs, a lack or inadequacy of roads, transport systems and referral hospitals, necessary for emergency care; political commitment was weak also and there was a lack of strong management systems with regular, supportive supervision.

Although donor contributions to safe motherhood programmes had increased somewhat since 1987, they remained far below the levels required for significant reductions in maternal and infant mortality rates. In addition, lack of coordination and information allowed ineffective interventions to continue, resulting in duplication of efforts and wastage of resources.

Internal and external: over the years, many interventions had been attempted in order to reduce maternal and neonatal mortality, many of which had proved ineffective. It was only recently that new evidence had demonstrated that maternal mortality could be reduced through cost-effective interventions that were feasible in resource-low settings. It was therefore imperative that WHO guidelines be adequately disseminated and put in place to ensure implementation of highly effective, evidence-based interventions.

There was a need to emphasize the special needs of vulnerable groups such as the poor, adolescents and unmarried women, migrants and women living in conflict situations. Appropriate operations research was needed to review the causes of, and solutions to, the problem of maternal and neonatal mortality, especially in these groups. The causes of mortality and morbidity are multidimensional and solutions require coordinated efforts that take account of economic, social, cultural and medical factors.

Relevance and adequacy

Achievement of the expected results remained highly relevant as additional countries continued to request WHO's support in implementing the Making Pregnancy Safer strategy. Furthermore, the WHO strategy is a crucial element in efforts to accelerate achievement of the targets for the Millennium Development Goals related to improving maternal health and reducing child mortality. The adequacy of WHO's achievements during the biennium was questionable, however, owing to the shortage of human and financial resources.

Budget adopted by the Health Assembly versus expenditure

Total expenditure, including the regular budget and other sources for 2002-2003, was US$ 13 500 000, representing 36% of the total programme budget (US$ 37 200 000). The difference between the total programme budget and the total expenditure was due to the shortage of extrabudgetary funds available throughout the biennium. This shortage resulted in a significant decrease in funds allocated to activities at the global, regional and country levels. This shortfall had a significant impact on the finalization of planned norms and tools, as well as the implementation of technical support to high-priority countries.

Total programme budget versus expenditure and expenditure by office (US$ thousand)

Area of work – programme budget	**37 157**
Area of work – expenditure	**13 539**

Expenditure by office:

Headquarters	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
8 772	2 062	127	706	812	517	543

Lessons learnt

- The evidence-based approach that WHO is emphasizing with the Making Pregnancy Safer strategy throughout the continuum of care – from the home to the referral hospital – is a winning strategy; time is required, however, so that this approach can be introduced fully to all decision-makers and health-care providers and included in pre-service training programmes. In this way, understanding and adoption of manuals, standards, recommendations and updated scientific evidence can be facilitated.
- Increased international and national funding, and improved coordination of existing efforts and resources are necessary to achieve the United Nations Millennium Development Goals for maternal and newborn health. WHO's coordinating role will be crucial in this endeavour.
- The critical ingredient for reducing maternal and newborn mortality is the provision of a continuum of care. The following key factors are also needed to complement and reinforce this: high social and political commitment (in particular, for high availability and utilization of skilled attendants and health care facilities for management of obstetric and neonatal complications), a functioning referral system and accessibility of services to the poorest sectors of the community.
- It would be preferable for WHO to move from a two-year to a five- or ten-year planning cycle in order to ensure continuity and sustainability of necessary activities, and secure funding commensurate with the high priority given to the initiative within the Organization.
- More effective working mechanisms should be established between the different levels of the Organization to ensure rapid, adequate and sustainable support to priority countries. This must include a monitoring framework, timely follow-ups and regular updates on new technical issues and tools.
- Intensified joint planning and streamlined reporting between headquarters, regions and countries need to be implemented in order to facilitate programme monitoring.
- Early collaboration with governments of countries where activities are being planned needs to be assessed to avoid prolongation of programme implementation. Operations research and process documentation need to be set up when new techniques are implemented at the community level in order to obtain new evidence for better decision-making.
- Improved partnership needs to be achieved with relevant partner agencies, departments of health, medical professional organizations, maternity hospital units in health institutions, in both the government and nongovernmental sectors in order to maximize use of current resources and avoid unnecessary duplication of activities.

WOMEN'S HEALTH

WHO objective(s)

To support and facilitate the development of policies, strategies and interventions that effectively address high priority and neglected needs of women throughout the life cycle, and improve women's access to good quality health care information and services.

Summary of achievements

- Evidence of the impact of sex differences and gender inequalities on health, health systems and services was gathered and used.
- Norms, standards and interventions to tackle gender discrimination and its consequences were elaborated, piloted and assessed. These included guidelines for integrating gender into HIV/AIDS programmes, research to address gender barriers in access to care, and ethical and safety guidelines for interviewing women who have been victims of trafficking and for research on domestic violence.[1]
- A gender perspective was further integrated into WHO's work following the finalization and distribution of the WHO gender policy in March 2002.[2] This was immediately followed by the establishment of a gender team and gender task force charged respectively with facilitating and overseeing the application of the gender policy at both headquarters and regional levels.
- Collaboration and advocacy with Member States, the United Nations and other international organizations were undertaken to address gender issues in health policies, programmes and research; and to build the necessary networks and partnerships to ensure that health systems respond adequately to the specific needs of women and men.
- The first draft of gender-sensitive indicators was developed with inputs from all the regional offices.
- Gender and health information sheets were produced and disseminated on ageing, blindness, disasters, HIV/AIDS, mental health, road traffic injuries, tobacco and tuberculosis, together with several reviews on the relevance of integrating gender in different areas (e.g. HIV/AIDS).[3]

Illustration of achievements at country, regional or global levels

- Data collection was completed in eight target countries for a multi-country study on the extent and impact on women's health of violence against women (the WHO Multi-Country Study on Women's Health and Domestic Violence Against Women). Country reports on Namibia, Peru and Thailand were also disseminated.
- A pilot initiative was developed in the WHO Region of the Americas on mainstreaming gender equity in health sector reform policies; the project enjoyed the active participation of stakeholders at every phase.
- More than 500 humanitarian workers in camps for refugees and internally displaced persons in Guinea were trained in basic counselling skills for the prevention and care of sexual and gender-based violence.

[1] *WHO ethical and safety recommendations for interviewing trafficked women.* Geneva, World Health Organization, 2003.

[2] Accessible on the WHO web site at the following address: http://www.who.int/gender/documents/policy/en.

[3] Accessible at the following address: http://www.who.int/gender/documents/fact/en.

Achievement of expected results

Results of reviews and research, and information on selected women's health matters, including attention to evolving gender issues, accessible to different stakeholders

Indicator	Baseline	Target	Achievement
Number of reviews, research and information pieces on women's health completed and disseminated to regions and countries through various means, including workshops, technical and user-friendly publications, and web-based communication	0	A gender and health information pack with 10 information sheets on gender and various health topics (in collaboration with relevant departments in WHO)	8 information sheets made available and disseminated in English, 4 in French
		Web site established	Web site running and used (36% of WHO Representatives and 225 000 hits in 12 months)
		At least 4 country reports from the WHO Multi-Country Study on Women's Health and Domestic Violence against Women published and disseminated in countries	Country reports for Namibia, Peru and Thailand launched and disseminated
		Dissemination strategy for gender and health information designed and implemented	Web site designed, uploaded and launched; virtual library finalized and launched for the GenSalud gender and health information gateway; GenSalud fact sheets and advocacy packs prepared (WHO Region of the Americas)

Standards, training modules and guidelines on women's health updated or developed in selected fields and used to support regions and countries in development or implementation of policies and programmes intended to improve availability and use of woman-friendly, gender-sensitive information, care, service and treatment, with particular attention to high-priority and neglected issues

Indicator	Baseline	Target	Achievement
Number of relevant documents (standards, training modules, guidelines) produced	0	WHO guidelines for the integration of gender into HIV/AIDS programmes developed	Draft guidelines discussed with regional offices and field staff
Number of regions and countries that have used or adapted those standards, training modules, or guidelines in developing or implementing policies or programmes	0	WHO guidelines for medico-legal care of victims of sexual violence	Guidelines available and being tested in countries (with 3 regional offices) Guidelines for research on violence against women available in 3 languages and guidelines for interviewing women who have been trafficked available and disseminated

Indicator	Baseline	Target	Achievement
	1	Ethical and safety guidelines for research on violence against women (translated into 2 languages)	Translation into Arabic, completion of a teachers' guide, student manual and policy guidelines (WHO Eastern Mediterranean Region)
		Guidelines prepared to improve the knowledge and skills of health personnel concerning female genital mutilation	Information, education and communication material concerning female genital mutilation disseminated to 27 countries in the African Region

Mechanisms to monitor progress in women's health and a core set of indicators giving due attention to gender considerations developed and validated

Indicator	Baseline	Target	Achievement
Number of regions and countries collaborating with WHO in the process of developing and using a core set of indicators on health of women	0	Development and testing of a core set of gender-sensitive health indicators	First draft set of gender-sensitive health indicators developed and put on the web with inputs from all regional offices. Regional offices began initiating work to adapt core set of indicators to test in countries

Adequate technical support provided to all regions and selected countries so that they can use the reporting process established for CEDAW[1] to strengthen monitoring of women's health and action to overcome problems as they are identified

Indicator	Baseline	Target	Achievement
Number of countries reporting to CEDAW which include women's health in their reports (on the basis of WHO-prepared guidelines)	Not established	Not estabished	Unable to report against this indicator
Number of countries tackling the problems identified			Unable to report against this indicator

[1] Obligation of all States ratifying the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).

Selected tools, guidelines, and capacity to incorporate gender considerations in work on a regular basis developed and applied throughout WHO

Indicator	Baseline	Target	Achievement
Number of tools and guidelines produced	0	Review of existing tools for gender analysis in terms of their applicability to health	Completed
Increase in financial and human resources to provide technical support for incorporation of gender considerations in activities		WHO guidelines for gender analysis in health completed and being used by WHO staff and others	Draft guidelines available and tested with staff from different departments in headquarters, regional and country offices[1]
Number of programmes throughout WHO using the tools developed and incorporating gender considerations in their work on a regular basis		All WHO departments or clusters to nominate gender focal points	Gender focal points nominated and meeting monthly from July 2002 to July 2003
		Integrating a gender perspective into the Millennium Development Goals	Document issued on integrating a gender perspective into the Millennium Development Goals[2]

Critical impediments

Internal: financial and human resource constraints delayed some activities and limited the impact of efforts to integrate gender considerations into the Organization's work. In some regions, work on women's health issues at the country level was fragmented across a wide range of subjects, without clear criteria, and without global or regional consensus on the issues identified.

External: there was a lack of understanding among some Member States and WHO partners of the potential to improve health outcomes of gender analysis when applied to health systems, research and interventions.

Relevance and adequacy

Work carried out at headquarters was relevant to the attainment of the global expected results, but was not adequately implemented owing to financial and human resource constraints. Some regional offices, however, stated that work carried out at country level lacked strategic focus and was not directly relevant or adequate for the attainment of the global expected results.

Budget adopted by the Health Assembly versus expenditure

Funds made available during the biennium were less than half of the US$ 15 524 000 approved by the Health Assembly, greatly restricting the ability of offices to contribute to the global gender and women's health agenda. The shortfall, which was largely due to a shortage of extrabudgetary funds, accounts for the significant difference between the amount budgeted and the US$ 6 472 000 recorded as expenditure.

[1] Accessible on the WHO web site at the following address: http://www.who.int/gender/documents/indicators/en/.

[2] "En-gendering" the millennium development goals (MDGs) on health (document WHO/FCH/GWH/03.1).

Total programme budget versus expenditure and expenditure by office (US$ thousand)

Area of work – programme budget	**15 524**
Area of work – expenditure	**6 472**

Expenditure by office:

Headquarters	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
4 591	1 027	122	554	143	30	5

Lessons learnt

- The consultation and joint planning between headquarters, regional and country levels, which was initiated in this biennium, will need to be strengthened to ensure that work carried out at all levels of WHO contributes to the improvement of women's health in countries.
- Advocacy for work on gender and women's health needs to be strengthened, particularly within WHO.
- Joint planning and regular discussions with regional office focal points for this area of work are required in order to strengthen impact at country level.
- A clear conceptual framework and strategy for WHO's work on gender and women's health as an area of work needs to be developed in order to better define a common work agenda that countries, regions and headquarters can focus on while accommodating regional differences.

HIV/AIDS

WHO objective(s)

To provide support to countries to develop effective health-sector responses to HIV/AIDS, with emphasis on strengthening the stewardship role, planning and managerial capacity, and financial base of the public health sector; and on the sector's capacity to deliver evidence-based, gender-sensitive prevention and care interventions, including approaches to antiretroviral treatments in resource-scarce settings.

Summary of achievements

- The global health sector strategy for HIV/AIDS was adopted at the Fifty-sixth World Health Assembly.[1] The strategy describes effective health sector interventions against HIV/AIDS and provides guidance to Member States on their incorporation into health systems. It also provides guidance on a number of subjects concerning the response to the HIV/AIDS epidemic, namely: strengthening health sector stewardship, planning, coordination, partnerships and resource mobilization.
- Major global policy guidance was provided in key intervention areas set out in the health sector strategy, including HIV counselling and testing, the prevention of HIV in infants, infant feeding, HIV prevention strategies for vulnerable populations (e.g., young people, injecting drug users and sex workers), and treatment and care (including policy and strategy guidance to address HIV/tuberculosis coinfection).
- The International HIV Treatment Access Coalition was launched as a partnership vehicle to promote expanded access to antiretroviral therapy. More than 140 partner organizations have signed up.
- Several new initiatives, tools and training materials were employed to strengthen second-generation surveillance of HIV/AIDS at country level.
- Expressions of interest were received from more than 80 countries wishing to participate in the Accelerating Access Initiative involving WHO, UNAIDS and other United Nations bodies together with five research-based pharmaceutical companies. Negotiations undertaken as part of the initiative led to the first major price reductions for research and development-based antiretroviral drugs in the developing world.
- Ten additional antiretroviral drugs were added to the WHO Model List of Essential Medicines.
- Two editions of guidelines for a public health approach to antiretroviral treatment in resource-limited settings were published, greatly simplifying the delivery of antiretroviral therapy and clinical follow-up in developing countries.[2]
- The AIDS Medicines and Diagnostics Service was established to provide enhanced technical support to countries in procurement and supply management for HIV-related commodities.

Illustration of achievements at country, regional or global levels

WHO and UNAIDS declared the global treatment gap to be a major public health emergency, and WHO launched a major thrust to expand access to antiretroviral treatment to at least three million people by 2005. At the time of reporting, thirty-five countries had asked to participate in the "3 by 5" initiative, which also included major technical inputs in the following areas: training and capacity building, fostering partnerships, surveillance, and monitoring and evaluation. At least 80% of funds raised to support "3 by 5" were directed to strengthening regional and country office capacity.

[1] See resolution WHA56.30.

[2] *Scaling up antiretroviral therapy in resource-limited settings: guidelines for a public health approach*. Geneva, World Health Organization, 2002; *Scaling up antiretroviral therapy in resource-limited settings: treatment guidelines for a public health approach. 2003 revision*. Geneva, World Health Organization, 2004.

Achievement of expected results

Global health sector strategy finalized and national strategies developed and implemented, with WHO support

Indicator	Baseline	Target	Achievement
Number of countries adopting and adapting for local implementation of the global strategy	Not established	Not established	The global health sector strategy for HIV/AIDS developed and then adopted by the Health Assembly in May 2003. 40 countries currently developing national plans linking care and prevention within the framework of the global health sector strategy for HIV/AIDS. Some 35 official country requests for participation in the "3 by 5" initiative received

Adequate support provided to countries to implement essential prevention-and-care packages that are evidence based and gender sensitive

Indicator	Baseline	Target	Achievement
Number of targeted countries adopting, and adapting for local use, WHO developed essential prevention-and-care packages	Not established	Not established	At least 26 Member States using the new version of the simplified guidelines for antiretroviral treatment
Number of targeted countries implementing cost-effective and appropriate strategies for identified, priority health-sector interventions, such as voluntary counselling and testing, prevention of mother-to-child transmission, and reduction of unsafe sex in adolescents	Not established	Not established	In regional and country offices, WHO supported 30 countries in the Accelerating Access Initiative to provide antiretrovirals and technically assisted more than 20 countries in the preparation of proposals for the Global Fund to Fight AIDS, Tuberculosis and Malaria. At least 50 countries implemented cost-effective strategies for the reduction of unsafe sex in adolescents
Number of targeted countries that have integrated prevention and care interventions for HIV/AIDS and sexually transmitted infections into existing health services	Not established	Not established	More than 70 countries have policies on the prevention of mother-to-child transmission in line with WHO recommendations
Number of targeted countries using WHO tools and guidance in the treatment of HIV-related conditions and in the administration of antiretroviral drugs	Not established	Not established	At least 70 countries integrated prevention and care of HIV/AIDS and sexually transmitted infections into existing health services

Gender sensitive surveillance tools and a database on WHO's activities contributing to the global HIV/AIDS response developed and disseminated widely

Indicator	Baseline	Target	Achievement
Number of targeted countries that have conducted at least one surveillance study in identified priority population subgroups	Not established	Not established	Analysis of the quality of surveillance systems in 132 countries performed; 88 now have HIV surveillance systems providing basic information to monitor HIV/AIDS epidemic

Indicator	Baseline	Target	Achievement
Number of regions and targeted countries on which comprehensive information is available on the database of WHO's activities contributing to the global HIV/AIDS response	Not established	Not established	Database containing strategic information on resource use established and made operational for planning purposes

Research tools and mechanisms in place for development and testing of new HIV vaccines and microbicides, and translating relevant research findings into interventions

Indicator	Baseline	Target	Achievement
Number of vaccine-related activities under way, for example, preparation of national plans, vaccine trials, and national studies to assess the effectiveness of prophylaxis for bacterial pathogens	Not established	Not established	14 countries implemented national AIDS vaccine plans and protocols for 4 vaccine trials, including 1 large-scale international phase III trial For microbicides, institutional research capacity strengthening achieved in 5 countries and coordination and supervision of clinical trials performed in 3 countries

Critical impediments

Internal: limited funding was made available to WHO country offices and staff were faced with the competing demands of activities in progress and new initiatives being established. At both the regional and country levels, the presence of additional staff would greatly enhance the capacity of the regional offices to respond to country needs. Insufficient financial and human resources prevented recruitment of the focal points who were needed at regional level to provide essential programme components and establish subregional block teams.

External: there is a heavy demand on ministries of health to provide leadership for the health sector response to HIV/AIDS, while mobilizing and supporting the response of other sectors. Time restrictions in the broader promotion and implementation of interventions at country level represent a further impediment. Furthermore, the dissemination and usage of normative and standard work require a reasonable time frame. The department's work in this regard started two years ago, giving it a low baseline. This was a short period, especially given the need to implement the plan of action by coopting many other partners in the public and private sectors, with the range of differing priorities that this implies.

Relevance and adequacy

The budget for the development of global normative work was relevant and adequate. However, the active dissemination of normative guidelines and tools and the promotion of best practices requires a significant increase in human resources and technical capacity in regional and, above all, country offices. Reaching the resource mobilization target of US$ 129 000 000 would greatly improve the Organization's capacity to deliver useful country support. By the end of 2003, WHO had only mobilized 60% of this target and optimal delivery at the country level was hampered as a result.

Budget adopted by the Health Assembly versus expenditure

As a result of the increased mobilization of resources against HIV worldwide and the awareness created by the United Nations General Assembly Special Session on HIV/AIDS (June 2001), the level of the programme budget was more than double that of the previous biennium. Nevertheless, it was not possible to raise more than US$ 80 000 000 which, in turn, affected the level of expenditure.

Total programme budget versus expenditure and expenditure by office (US$ thousand)

Area of work – programme budget	**129 812**
Area of work – expenditure	**55 854**

Expenditure by office:

Headquarters	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
21 455	19 544	1 022	3 071	3 659	3 018	4 085

Lessons learnt

- Sound and realistic baselines and targets should be set during the preparation of the programme budget. To achieve this, systematic, consistent and comprehensive planning involving joint participation of headquarters and regional and country offices is required.
- The potential of greater collaboration between regions should be exploited.
- Well-targeted advocacy is essential in the implementation of HIV/AIDS care and prevention activities at the country level.
- Greater technical involvement of WHO in the preparation of Global Fund proposals would generate increased resources at the country level.
- Country offices need to be strengthened in order to acquire the core competencies required for an adequate response to the HIV/AIDS epidemic.

SUSTAINABLE DEVELOPMENT

WHO objective(s)

To equip governments and civil society with the knowledge and skills to tackle new and emerging challenges to health in development in the key areas of poverty reduction, globalization, cross-sectoral action, and human rights, with a special focus on indigenous people and equity between men and women.

Summary of achievements

- It is widely acknowledged that the work of WHO has made a significant contribution to raising the profile of health as an issue in sustainable development. As a result, the importance of better health is more widely taken into account by governments and civil society worldwide, both in its own right and as a major factor in economic development and poverty reduction. Evidence of this is widespread, from the statements of governments and the deliberations of the United Nations to the increase in development assistance for health and the prominence given to health in trade and security negotiations.
- WHO developed a widely accepted conceptual and analytical base linking poverty and ill-health and examined the role of health in national poverty reduction strategies. The Organization also carried out work demonstrating the links between public health and trade agreements and showed how the issue of human rights – and in particular the right to health – can help advance the health and poverty agenda. This body of information was used by the Organization to develop advocacy and policy positions as well as by governments and other development agencies. The challenge for the future is to ensure closer collaboration with Member States in developing the capacity to act on this issue.

Illustration of achievements at country, regional or global levels

- Health featured prominently in the agreements reached at the International Conference on Financing for Development (Monterrey, Mexico, 2002), the WTO Ministerial Conference (Doha, 2001) and the World Summit on Sustainable Development (Johannesburg, South Africa, 2002).
- The findings of the WHO Commission on Macroeconomics and Health were widely quoted in major media, academic and national policy settings.
- At least three regional offices began defining health and poverty reduction regional policy frameworks.
- The Healthy Environments for Children Alliance was launched globally.
- Capacity-building materials and experiences were developed on health and poverty reduction strategy papers and health and trade agreements.
- A trade and public health guide was produced, entitled "WTO agreements and public health: a joint study by the WHO and the WTO secretariat".

Achievement of expected results

International and national development agendas significantly influenced, and public health concerns given a more prominent place in the broad development context

Indicator	Baseline	Target	Achievement
Increase in the number of WHO policy recommendations and positions linked to the broad development agenda	Not established	Not established	As a direct result of WHO's involvement, health featured in several major international conferences, including the WHO Commission on Macroeconomics and Health, which was widely quoted in international and national press following its launch at the beginning of the biennium and subsequent follow-up process in several countries

Indicator	Baseline	Target	Achievement
Increase in number of declarations, policy recommendations, and reports emanating from major international processes highlighting the role of health in development	Not established	Not established	Health and poverty received considerable attention at regional committees and in many individual countries. A regional framework for health and poverty was prepared in the WHO Eastern Mediterranean Region. In the African Region, a regional strategy on health and poverty reduction was developed by the poverty and ill-health programme which will form the basis for further work. Technical support was also provided to countries in developing and improving the health component of their respective national poverty reduction strategy papers

Global knowledge banks on health in development and on health and human rights improved, expanded and made available to policy- and decision-makers

Indicator	Baseline	Target	Achievement
International research agenda and strategy established	Not established	Not established	Significant work performed on the following: health impact of globalization, health contents of poverty reduction strategy papers, international trade agreements and health, impact of trade on health, intersectoral policy and planning, support for health and human rights, and follow-up of Commission on Macroeconomics and Health for which initiatives launched at regional levels and national commissions established in Bangladesh, India, Myanmar and Sri Lanka
Increase in relevant results from scientific activities	Not established	Not established	In all areas, work extended beyond generation of knowledge to exploring its application in different contexts. Work started on a study of health of indigenous children – in conjunction with the environment and promotion of health programme, which is in process of finalization
Web site established and information for policy- and decision-makers made more accessible	Not established	Not established	Web site established for the World Summit on Sustainable Development, featuring all WHO preparatory activities, documents and event announcements relating to health and sustainable development at World Summit

WHO partnerships expanded with development agencies, financial institutions, academia, and civil society

Indicator	Baseline	Target	Achievement
Increase in partners actively involved in cosponsored and joint initiatives and actions	Not established	Not established	Increased attention to health as a component of poverty reduction by donors resulting from partnership established with the OECD Development Assistance Committee; training workshops on health and poverty reduction organized with World Bank and Harvard University. WHO influential in creation and design of new public-private partnership – the Global Fund to Fight AIDS, Tuberculosis and Malaria
Number of new and expanded multidisciplinary networks in operation	Not established	Not established	WHO established a new civil society initiative; experience gained from wide range of national healthy city networks; support provided for the United Nations Permanent Forum on Indigenous Issues; Healthy Environments for Children initiative launched at World Summit on Sustainable Development. At least 1 formal working relationship established with a research and training institution in the programmes for health and sustainable development. An agreement signed in Kisumu, Kenya, with the Tropical Institute of Community Health and Development in Africa for development of health in the region

Capacity for institutional and human resources development strengthened

Indicator	Baseline	Target	Achievement
Increase in capacity-building activities such as dissemination of materials for guidance, information and training	Not established	Not established	Wide range of material produced (as mentioned above); WHO also translated these materials into capacity-building training courses and workshops, notably in relation to health as a component of poverty reduction strategy papers, and health and trade agreements; significant steps taken in building regional strengths and health and human rights; contribution made to launch of new module on poverty and health as part of the workshop on evidence and information for policy and training[1]

Critical impediments

Internal: expanding the scope of WHO's work into areas such as trade, human rights, and rights and economic development requires people with a broader range of skills, and intensive work to forge consistent positions across the Organization.

[1] Quantitative indicators are not able to measure these processes in a convenient way owing to their qualitative, policy-oriented character.

External: despite much progress, at the end of the period under consideration the place of health on the development agenda was still not secure. Continued and strengthened advocacy efforts were required to ensure sustained commitments. Collaborative work and partnership building need time and significant staff numbers.

Relevance and adequacy

Both the WHO objective and the expected results were poorly formulated for this area of work and achieving the expected results would not necessarily have led to the achievement of the WHO objective.

Budget adopted by the Health Assembly versus expenditure

Expenditure of US$ 21 385 000 exceeded by 16% the programme budget of US$ 18 419 000. This was mainly owing to the inclusion of funds provided to the Commission on Macroeconomics and Health, which has been actively engaged in influencing international and national development agendas, ensuring that priority is given to improving the effectiveness of health delivery systems and increasing internal allocation of resources to health.

Total programme budget versus expenditure and expenditure by office (US$ thousand)

Area of work – programme budget	**18 419**
Area of work – expenditure	**21 385**

Expenditure by office:

Headquarters	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
8 098	6 099	790	1 236	3 559	1 394	209

Lessons learnt

- Work in several WHO regions and actions to follow up the Commission on Macroeconomics and Health has drawn attention to the need for increased commitment to development assistance if countries are to develop realistic investment plans for health within poverty reduction frameworks.
- In the WHO European Region, the healthy cities approach has proven to be an effective means to integrate health into Agenda 21 strategies and activities.
- Experience from the follow-up to the Commission on Macroeconomics and Health shows that countries are putting forward more complex agendas for health development than were originally outlined in the report.
- Coordination of the overall health and development agenda has been constrained by organizational fragmentation within WHO; there is a growing need for interunit and interdivisional collaboration especially in respect of activities for achieving the Millennium Development Goals.
- The creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria, for example, has placed major, unforeseen demands on WHO's resources at all levels. The Organization therefore needs to adopt a more flexible, incorporative approach to enable it to adjust more easily to such eventualities.

NUTRITION

WHO objective(s)

To provide Member States and the international community with authoritative technical guidance and collaboration, thereby improving their effectiveness to identify, prevent, monitor and reduce malnutrition and diet-related problems.

Summary of achievements

- WHO successfully developed field-friendly, authoritative treatment guidelines and teaching modules on the management of severe malnutrition.[1] Centres applying these guidelines have reportedly reduced hospital case fatality rates from a pre-training level of 20% to 50% to a post-training level of 8% to 15%.
- In the light of recommendations made by WHO following a technical consultation on the nutrient requirements for people living with HIV/AIDS, held in May 2003, many governments, organizations of the United Nations system, international organizations and nongovernmental organizations are revising their guidelines. This has encouraged heightened awareness about the central role of nutrition in HIV care and support packages.
- The Joint WHO/FAO Expert Consultation on Diet, Nutrition and the Prevention of Chronic Diseases reviewed the latest scientific evidence concerning six major diet-related chronic diseases – overweight/obesity, type 2 diabetes, cardiovascular diseases, cancer, dental diseases and osteoporosis – and updated the work of a 1989 WHO study group on population nutrient intake goals. The report of the Expert Consultation was significant as it incorporated a review of the likely implications of nutrient recommendations and dietary guidelines for food supply and production. It also recommended physical activity, recognizing that to achieve the best results in prevention of chronic diseases, strategies and policies should fully recognize the essential role of diet, nutrition and physical activity. The report, applying a life-course approach, recognized that both undernutrition and overnutrition play a role in the development of chronic diseases and that chronic diseases in adulthood reflected cumulative differential lifetime exposures to various damaging environments.
- Member States and the international community were provided with authoritative technical guidance and collaboration, thereby improving their effectiveness to identify, prevent, monitor and reduce malnutrition and diet-related problems.

Illustration of achievements at country, regional or global levels

- Technical collaboration between WHO headquarters and Oman (one of six countries involved) was strengthened as part of the implementation of the WHO multicentre growth reference study.
- Technical collaboration was improved with countries on inpatient management of severe malnutrition. The objective was to reduce malnutrition-related mortality, especially in countries with a wasting rate of 10% or more (child's height related to his/her weight compared to the reference population) and with a mortality of 15% and above (hospital case fatality rate) in children under five.
- Technical support, and in some instances financial support, was provided by staff from the Department of nutrition for health and development at headquarters to the following countries: Afghanistan, Bhutan, Bolivia, India, Lesotho, Myanmar, Swaziland, and Zambia.
- Less than a year after the Framework for Priority Action on HIV and Infant Feeding was developed jointly by WHO and nine organizations of the United Nations system, nine countries in sub-Saharan Africa used it to develop their plans of work and started implementation. Most of these countries also used the framework to revise their policies on HIV and infant feeding.
- A series of regional training courses to help strengthen and implement national food and nutrition plans and policies were held in the WHO African, European and Western Pacific Regions, using the training modules developed by WHO, which integrate high-quality tools and materials developed by various agencies in response to emerging food and nutrition issues including, inter alia: famine across southern Africa and the lack of robust surveillance systems; the HIV/AIDS epidemic; confusion regarding the role and safety of genetically modified foods; food safety crises; globalization of food and trade, especially the formation of global governance bodies such as WTO; and the rapid rise of obesity and other diet-related chronic diseases.

[1] Training course on the management of severe malnutrition (document WHO/NHD/02.4).

Achievement of expected results

Nutrition policies, strategies and advocacy platforms developed and promoted

Indicator	Baseline	Target	Achievement
Number and proportion (regional and global) of targeted countries that have prepared national nutrition policies, strategies and advocacy statements	0	12 countries to revise and strengthen their existing national nutrition plans and policies	Achieved. 12 countries further revised and updated their national plans and policies. At the time of reporting, 146 countries had intersectoral national nutrition plans and policies

Global nutrition databases – on protein-energy malnutrition, iodine deficiency disorders, vitamin A deficiency, anaemia, obesity, breastfeeding, and national nutrition plans – expanded and accessible for global and national nutrition surveillance

Indicator	Baseline	Target	Achievement
Quantitative and qualitative evidence on coverage and function of the global nutrition databases for global and national surveillance	The coverage of the 7 databases ranges from 0 to 185 countries and territories	Targets range from 92 to 187 countries and territories	92 to 187 countries and territories were covered. Each data bank contains approximately 400 to 796 surveys

Adequate support provided to Member States for strengthening and implementing sustainable national nutrition policies and plans

Indicator	Baseline	Target	Achievement
Number and proportion (regional and global) of countries receiving technical and/or financial support that have developed and strengthened their national nutrition policies, programmes, and plans	0	75 (39%) countries to receive technical and/or financial support	75 countries

Nutrition standards, guidelines, training manuals, methodologies, and criteria developed and disseminated for assessing, preventing and managing the major global forms of malnutrition

Indicator	Baseline	Target	Achievement
Number and nature of nutrition standards, guidelines, methodologies, and training manuals produced	0	47 nutrition standards, guidelines, methodologies and training manuals to be produced	40 produced. 7 delayed or cancelled owing to shortage of funds and staff time

Support provided to countries for tackling the special needs of nutritionally vulnerable, food-insecure groups, particularly through technical collaboration with the World Food Programme and its food-assisted development projects, and action to improve the nutritional status of vulnerable groups, including infants and young children, and disaster-affected populations

Indicator	Baseline	Target	Achievement
Quantitative and qualitative evidence of technical support provided, especially through the World Food Programme, to strengthen frontline action for food insecure, vulnerable, or disaster-affected populations	0	Number of interventions: Through WFP: 14 Other: 8	Number of interventions: Through WFP: 15 Other: 6 (Support was provided to Afghanistan, Cambodia, Cape Verde, China, Ethiopia, Gambia, Guinea-Bissau, Liberia, Mauritania, Myanmar, Niger, Sierra Leone, South Africa and others)

Critical impediments

Internal: shortage or late arrival of anticipated funds and unforeseen changes in WHO policies sometimes resulted in the delay or cancellation of activities, including accessing suitable technical expertise.

External: inadequate national capacity to implement nutrition programmes was an impediment in some regions.

Relevance and adequacy

Expected results were generally relevant and adequate and were achieved despite funding constraints.

Budget adopted by the Health Assembly versus expenditure

Expenditure represented almost 100% of the programme budget. There was also some carry-over of funds from other sources, ensuring continuation of activities in progress.

Total programme budget versus expenditure and expenditure by office (US$ thousand)

Area of work – programme budget	**14 475**
Area of work – expenditure	**14 044**

Expenditure by office:

Headquarters	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
8 380	963	1 234	595	644	1 307	921

Lessons learnt

- Advocacy is needed to increase Member States' commitment to nutrition policy and therefore ensure that nutrition is placed higher on the political agenda. Regional committees, national and international meetings represent opportunities for raising awareness.
- Special efforts and funds are required for databank activities, especially to get better data on morbidity and mortality in relation to nutritional disorder. This is needed because of the increasing demand for data not only from international organizations and nongovernmental organizations, but also from Member States. In addition, high-quality data are required to identify emerging issues, evaluate strategies and mobilize public health authorities and the donor community.

- Web sites and other computer tools proved an effective means of disseminating information, and their use should be developed.
- The importance of collaboration and communication between national nutrition counterparts, country offices, regional offices and headquarters cannot be emphasized too strongly, and should become a priority for all staff in this area of work.
- The process of developing workplans, and performing monitoring, evaluation and assessment has been very helpful in identifying strengths and weaknesses in implementation and effectiveness of activities.

HEALTH AND ENVIRONMENT

WHO objective(s)

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

Summary of achievements

- During the biennium, the Organization provided normative guidelines, health-based impact assessments of environmental and occupational risks and related policies, economic valuations of environmental and occupational health interventions, as well as materials and good practice tools for managing environmental and occupational risks.
- Outreach services were improved, and support was provided to a number of Member States in addressing various aspects of occupational and environmental health.
- Progress monitoring, particularly in the area of water supply and sanitation was successfully conducted.
- The Healthy Environments for Children Alliance was launched jointly with a number of international and national partners from all sectors.
- The healthy settings approach continued to be a key tool for implementing environmental and occupational health-promoting policies in all WHO regions.
- Work on prevention of, preparedness for, and response to environmental emergencies was strengthened.
- The Organization's work was supported by networks of centres of excellence.

Illustration of achievements at country, regional or global levels

- The WHO/ILO Joint Effort on Occupational Health and Safety in Africa was launched.
- Guidelines for drinking-water quality were completed and support was provided to countries for their implementation.[1]
- A major assessment of health impacts of climate change was carried out and a book published in collaboration with UNEP and WMO.[2]

[1] *Guidelines for drinking-water quality*. Vol. 1: 3rd ed. Geneva, World Health Organization, 2004, in press. Online version available at http://www.who.int/water_sanitation_health/dwq/gdwq3/en/.

[2] Campbell-Lendrum DH et al. *Climate change and human health: risks and responses*. Geneva, World Health Organization, 2003.

Achievement of expected results

Comprehensive policy guidance and advocacy platforms based on evidence drawn up to promote good practice in managing priorities in environmental health and emerging environmental threats

Indicator	Baseline	Target	Achievement
Increased use of WHO policy guidance by sectors other than health with responsibility for environmental management	Not established	Not established	Targeted policy guidance provided on the following: ultraviolet radiation; depleted uranium; response to chemical and nuclear incidents; occupational health and safety (with emphasis on workplace health promotion); health workers and national systems (particularly in Africa), with national action plans promoted in 43 countries; elimination of silicosis; climate change and health (including contribution to Millennium Ecosystem Assessment). WHO also actively involved in reporting on water and sanitation for the United Nations Commission on Sustainable Development, chairing UN Water, and participating in the Systemwide Initiative on Malaria and Agriculture. Also secured health inputs for draft paper on the "Right to Water"

Information systems established and maintained for risk assessment and communication, and for advice on decision-making in environmental health, based on evidence from research and monitoring of status and trends in areas of global or national significance

Indicator	Baseline	Target	Achievement
Extent to which the information provided covers existing and newly emerging environmental health risk factors	Not established	Not established	Evidence-based, targeted actions initiated or completed on the following: depleted uranium, electromagnetic fields, ultraviolet radiation, thermal effects of radiofrequency fields, water and sanitation coverage, health care waste, 25 individual chemicals, a large number of food chemicals, workplace health issues (including pesticide exposure, stress, psychological harassment, musculoskeletal disorders, needlestick injuries and silicosis), indoor use of biomass fuels, and climate change, as well as actions to promote healthy settings (healthy schools, healthy settings for children)
Evidence of use of the information by the public and private sectors in Member States	Not established	Not established	A new electronic information system on healthy environments for children established. The global network of WHO collaborating centres in occupational health set up, producing a regular newsletter. Network of poison information centres, and network on chemical incidents also in place

Adequate support provided to Member States for creating and strengthening capability in national and local institutions to implement effectively national plans for environment and health action

Indicator	Baseline	Target	Achievement
Number of national plans for environment and health action drawn up	Not established	Not established	A plan for sub-Saharan Africa developed. In cooperation with the WHO Regional Offices for Africa and the Eastern Mediterranean, the WHO/ILO Joint Effort on Occupational Health and Safety in Africa launched, with activities initiated in countries of the 2 WHO regions. Occupational health plans developed in at least 2 countries. An Asian joint effort initiated with the Regional Offices for South-East Asia and the Western Pacific. Support provided to establish national plans in waste management (9 countries), occupational safety and health (5 countries), climate change and health in small island States, children's environmental health, wastewater management (9 countries) and chemical safety (8 countries)
Proportion of targeted countries in each region monitoring or reporting on implementation of plans for environment and health action	Not established	Not established	Information on progress in individual countries not available

Capacity of responsible local and national institutions enhanced in prevention of and response to chemical incidents and poisonings, radiation accidents, and other technological emergencies or environmental disasters

Indicator	Baseline	Target	Achievement
Access of countries to technical guidance and cooperation in situations of natural and manmade emergencies	Not established	Not established	A mechanism to respond to biological, chemical and radiation threats initiated. 8 new poison centres established, 6 strengthened and 17 under way. Guidance provided and response networks established or strengthened in fields of chemical safety, water and sanitation, and radiation

Scientific evidence available on the emergence of health impacts of different socioeconomic sectors (energy, agriculture, transport) and of long-term global change in climate, biodiversity, water resources and disease-vector habitats

Indicator	Baseline	Target	Achievement
Extent to which global health and environment issues are addressed	Not established	Not established	Work expanded in the following fields: radiation (radon gas, electromagnetic fields), biodiversity (research agenda for Africa developed), water-related diseases (schistosomiasis), vector-borne diseases related to water and sanitation, climate change and other issues related to global change. New issues covered included ultraviolet radiation, water resources development, household energy and indoor air pollution and health contributions to Millennium Ecosystem Assessment
Number of environmental health impact assessments completed	Not established	Not established	9 environmental health impact assessments completed and national environmental health impact assessment guidelines prepared[1]

International alliances and networks of scientific and training institutions established for assessment of environmental health risks, formulation of guidance on environmental policies with a health dimension, and for children's environmental health

Indicator	Baseline	Target	Achievement
Number of intergovernmental bodies and associations cooperating on health and environment matters	Not established	Not established	12 bodies, alliances and associations cooperated with WHO on aspects of radiation, occupational health, chemical safety, household water treatment and safe storage, healthy environments for children, and indoor air pollution
Evidence of health and development aspects being incorporated effectively into environmental management policies and programmes	Not established	Not established	This indicator deleted during the mid-biennium review since outcome included in first indicator

Health impact of occupational and environmental risks comprehensively assessed and translated into evidence-based guidelines as the scientific starting point for harmonized environmental health standards, classifications, terms and regulations

Indicator	Baseline	Target	Achievement
Proportion of environmental risks addressed that have a significant health dimension	16 environmental health risk areas are available	9 new guidelines on environmental health issues to be completed and/or published	Prior to developing guidelines, environmental burden of disease assessments conducted addressing 6 environmental and 5 occupational risk factors, as well as ionizing and ultraviolet radiation. Assessments completed of health risks of radon gas, depleted uranium, electromagnetic fields and radiofrequency fields

[1] Available online at http://www.who.int/hia/about/guides/en.

Indicator	Baseline	Target	Achievement
Number of national and international legal and regulatory instruments making use of WHO environmental health criteria and guidelines	In 6 areas the WHO guidelines are being used as the scientific starting point for developing legislation or regulations	3 more applications of WHO guidelines to be achieved	Guidelines on drinking-water quality, air quality, recreational water, ultraviolet radiation, electromagnetic fields, health care worker protection, food additives and contaminants, pesticide and veterinary drug residues continued to form basis for international and national standards. New developments included adoption of Global Solar UV Index by several countries, use of depleted uranium assessment as a basis for evaluating health risks in a number of post-conflict investigations, and promotion of harmonized standards for electromagnetic fields. Approaches to provide guidance for legislation under development include needlestick injury prevention for health care workers and health care waste management

Tools and instruments for good practice in environmental management devised on the basis of innovative approaches to reduction of health risk from exposure to harmful environmental agents, adverse environmental changes, workplace hazards, and new technological developments

Indicator	Baseline	Target	Achievement
Access of national environmental managers to documents and publications in both electronic and physical form that provide guidance on reduction of health risk	Not established	Not established	A user-friendly web portal for health and environment developed together with new, user-friendly web sites for most fields of work
Increased use of WHO health protection advice in local, national and regional environmental management	Not established	Not established	Environment and health staff provided to a number of countries (e.g. 7 in WHO Eastern Mediterranean Region). Support provided to countries (e.g. Cambodia) to establish water quality standards, to 14 countries to strengthen drinking-water monitoring, and to 2 countries to put air quality monitoring programmes in place

Critical impediments

Internal: lack of resources hampered work in some fields and administrative procedures needed further streamlining, particularly in relation to budget and finance, resource mobilization and donor relations. Resources at regional and country levels were mostly inadequate, and procedures for budget management were too cumbersome in some regional offices.

External: the actual use of outputs by other sectors was not under the control of this area of work, while data on emerging risks are scarce by nature; the reliance on voluntary contributions by scientific experts led to delays in finalizing scientific assessments; building alliances and collaboration with external partners required better-defined operational procedures; the security situation in some regions, and the urgency of dealing with acute problems diverted interest away from addressing environmental determinants in some countries. In general, prevention is often not treated as a priority issue.

Internal and external: despite improved cross-sectoral work (e.g. on basic sanitation) health and environment still needed to be better integrated into the public health agenda; the importance of environmental determinants of health was not fully recognized within the health sector.

Relevance and adequacy

Achievement of the expected results continued to be relevant. While the normative work was completely adequate, promotion of its use at regional and country levels was not optimal. Better interaction was needed to tailor normative and scientific work to the actual needs of Member States, and to improve accessibility and application of available information.

Budget adopted by the Health Assembly versus expenditure

The difference between total expenditure and the programme budget was due to additional fundraising activities and allocation of funds to the Healthy Environments for Children Alliance upon its establishment.

Total programme budget versus expenditure and expenditure by office (US$ thousand)

Area of work – programme budget	**50 076**
Area of work – expenditure	**56 560**

Expenditure by office:

Headquarters	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
30 272	2 499	1 802	2 056	12 943	4 436	2 552

Lessons learnt

- A clearer focus on key actions and better coordination with other key players are required to define WHO's unique role in this area.
- The expected results were too fragmented and sometimes overlapping, and indicators were not easily quantifiable. An improved approach was followed for 2004-2005, and the indicators were revised. Further refinement is foreseen for 2006-2007.
- Work needs to be better coordinated with regional and country offices. In planning for the 2004-2005 biennium, a closer and more participatory consultation process was followed and regular consultations on joint approaches to implementing operational workplans have started.
- Programme planning would benefit from a better-coordinated cycle, allowing country and regional offices to identify priorities first, on the basis of which headquarters could then define its own contribution.
- Feedback from country offices will provide a major source of information for the development of the programme budget 2006-2007.
- Active partnerships will be further pursued at all levels. Strategic approaches to resource mobilization and partnerships will be designed, and resource distributions made, using a more strategic approach. Better marketing, promoting the use of WHO normative guidelines, is also needed. This will require the active involvement of regional and country offices.
- More country-based work in the area of health and environment will be pursued from the beginning of the next biennium, and better use will be made of WHO collaborating centres and other centres of excellence.
- Coordination with partners could be improved at all levels, particularly cross-sectoral coordination.

FOOD SAFETY

WHO objective(s)

To create an environment which enables the health sector, in cooperation with other sectors and partners, effectively and promptly to assess, communicate and manage foodborne risk.

Summary of achievements

- In addition to WHO's draft global strategy for food safety, endorsed by the Executive Board at its 109th session,[1] the WHO regions are now guided in their work either by food safety strategies (the Region of the Americas and the South-East Asia, Eastern Mediterranean and Western Pacific Regions) or by food safety resolutions adopted by the regional committees (the African and European Regions).
- Several guidelines were developed in collaboration with key partners, such as FAO and Codex, in order to assist countries in assessing risks and handling new products derived from biotechnology.[2]
- A number of global surveillance mechanisms, including the Global Environment Monitoring System/Food Contamination Monitoring and Assessment Programme (GEMS/Food), WHO Global Salmonella Surveillance and the FAO/WHO Acrylamide in Food Network – were developed or strengthened during the biennium. Workshops, training activities and studies were conducted in countries and at regional levels to improve contribution to and uptake of these mechanisms.
- The first international microbiological risk assessments on Salmonella spp. were made using data from 32 countries.
- The FAO/WHO Global Forum of Food Safety Regulators was convened in Marrakech, Morocco, in 2002 to allow for the sharing of information and experiences.
- Country strategies were developed for food safety improvement; these included structural changes to reflect new risk-based thinking.
- New developments to further risk-based interventions in countries were supported by new global guidelines for risk assessment of issues related to microbiological hazards and biotechnology in food.

Illustration of achievements at country, regional or global levels

- As part of the WHO Global Strategy for Food Safety, WHO promoted a thorough review and optimization of the work of the Codex Alimentarius food standards system in collaboration with FAO, an external evaluation group and an independent expert panel. The full review process, including extensive consultation between Member States was successfully completed within a relatively short time frame (eight months). The review recognized health and the participation of developing countries as main priorities for Codex. WHO's work in relation to Codex was endorsed by the Fifty-sixth World Health Assembly.[3]
- The Trust Fund for increased participation in Codex, developed in consultation with Member States as well as through deliberations in the Codex Alimentarius Commission and the Health Assembly, was launched in 2003.
- FAO/WHO Food Control Guidelines were developed and published in 2002-2003,[4] incorporating recent developments in food safety and endorsing a risk-based, "farm-to-fork" approach in dealing with food safety hazards.

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

[2] Accessible online at http://www.who.int/foodsafety/en.

[3] See resolution WHA56.23.

[4] Accessible online at http://www.who.int/foodsafety/publications/capacity/en/English_Guidelines_Food_Control.pdf.

Achievement of expected results

International consensus established on the rules for assessing risk and handling foods, including those derived from biotechnology

Indicator	Baseline	Target	Achievement
Proportion of targeted countries adopting rules for assessing risk and safety of foods in accordance with those of WHO	0 for microbiological risk assessments	10 countries	Not tracked
Proportion of new Codex texts consistent with established WHO policies and procedures for assessing risk and safety of foods	Not established	Not established	Codex finalized 36 standards, 18 of which based on WHO/FAO risk assessment procedures. At the end of the period under review, Codex had yet to develop new documents incorporating outcome of FAO/WHO microbiological risk assessments

International agreement reached on foodborne hazard and disease surveillance in order to enable Member States to produce relevant information for risk assessment at national level and for international standard-setting

Indicator	Baseline	Target	Achievement
Number of internationally agreed surveillance mechanisms established for foodborne hazards and specific diseases Number of countries that routinely collect additional information needed for assessing microbiological risk in cases of foodborne illness	The GEMS/Food database has existed for several years. The Global Salmonella Surveillance network has existed since 2000. No other international mechanisms for surveillance existed at the start of the biennium. As a new scientific discipline, the baseline would therefore be 0	Number of countries participating in global surveillance Significant increase (>20) in countries providing data suitable for use in microbiological risk assessment	Data available from 42 countries in GEMS/Food database The Global Salmonella Surveillance network now has over 800 members from 140 countries and hosts training courses in all WHO regions FAO/WHO Acrylamide in Food Network facilitates data sharing 1 international risk assessment finalized and published on Salmonella,[1] using data from 32 countries

Network improved for communicating food-safety information and sharing risk-assessment methodology and data, including emergency information

Indicator	Baseline	Target	Achievement
Number of new risk assessments conducted in accordance with risk-assessment methodology as provided by WHO	Not established	Reach informal targets in at least 120 Member States	Not tracked. However, mailing list for the WHO newsletter, *Food Safety News*, which provides information on risk assessment, now includes 1800 informal contacts in 162 countries. Training courses for microbiological risk assessment aimed at building capacity in data collection and risk modelling developed and run. First 2 courses in Beijing and Cairo covered 21 developing countries

[1] *Risk assessments for salmonella in eggs and broiler chickens*. Geneva, World Health Organization, 2002 (Microbiological risk assessment series, No. 2).

Indicator	Baseline	Target	Achievement
Number of countries that have institutions participating in the Global Environment Monitoring System/Food Contamination Monitoring and Assessment Programme (GEMS/Food)	35 countries	Increase of country participation in GEMS/Food	Number of countries providing data for GEMS/Food increased from 35 to 42

Participation in the health-related committees of the Codex Alimentarius Commission expanded, and the requirements of Codex Alimentarius standards incorporated into national legislation

Indicator	Baseline	Target	Achievement
Number of Member States that have incorporated selected Codex Alimentarius standards into national legislation	Not established	Not established	Not tracked. However, study on participation of Member States in Codex work showed 127 countries participated in an overall total of 40 meetings during period 2000-2002, of which 93 were developing countries and 34 developed countries

Collaborative network of research institutions launched in order to provide data and methodology relevant to assessment of microbiological risk

Indicator	Baseline	Target	Achievement
Number of targeted institutions involved in a WHO network for providing data and methodology relevant to assessment of microbiological risk	Such networks did not exist at the start of the biennium	The initiation of work with collaborating centres	Redesignation of 4 WHO collaborating centres involved in work related to microbiological risk assessment, representing new emphasis on providing support to WHO's work promoting microbiological risk assessment. 8 relevant institutions in 7 different Member States selected as potential collaborating centres in this area

Member States and the Codex Alimentarius system equipped with internationally reviewed risk assessments for major microbiological pathogens in food with a view to defining management options aimed at reducing foodborne disease

Indicator	Baseline	Target	Achievement
Number of completed microbiological risk assessments provided to Codex Alimentarius Commission and Member States	Since this marks initiation of such work, the baseline value is 0	It is anticipated to initiate between 1 and 3 full microbiological risk assessments per biennium	General guidelines on microbiological risk assessment developed, providing descriptive guidance on how to conduct risk assessment in various contexts utilizing a variety of tools and techniques. Guidelines on hazard characterization for pathogens in food and water published[1] Microbiological risk assessment initiated in certain countries, and experts involved from more than 20 countries in this work at international level

[1] *Hazard characterization for pathogens in food and water: guidelines.* Geneva, World Health Organization, 2003 (Microbiological risk assessment series, No. 3).

Recommendations drawn up on evaluation and use of technology with the potential to prevent foodborne disease

Indicator	Baseline	Target	Achievement
Number of WHO and joint WHO/FAO recommendations available on evaluation and use of technologies to prevent foodborne diseases	Not established	Not established	3 major recommendations made available Consultation completed on safety assessment of foods derived from genetically modified animals, including fish. Codex principles for the risk analysis of foods derived from biotechnology, and Codex guidelines for the conduct of food safety assessment of foods derived from recombinant DNA plants and microorganisms adopted by the Joint FAO/WHO Codex Alimentarius Commission in July 2003
Number of food additives, pesticide and veterinary drug residues and contaminants evaluated by WHO expert advisory bodies	Each biennium, between 20 and 60 assessments performed	To keep the level of evaluations within range indicated in the baseline	The relevant numbers of evaluations for this biennium are: food additives: 27, pesticides: 26, veterinary drug residues: 7 and contaminants: 5

Critical impediments

Internal: resources at regional and country levels were generally inadequate; it is only recently that all regions have allocated dedicated staff for food safety. Furthermore, as the Department of food safety was only created at headquarters in November 2002, budget and administrative procedures are new, and could be improved.

External: data on foodborne diseases as well as information on emerging risks are scarce, both in developed and developing countries. Reliance on voluntary contributions by scientific experts led to delays in finalizing scientific assessments. Collaboration with FAO improved significantly, but scope remained for better cross-sectoral collaboration between health and agriculture at the national level in most countries.

Relevance and adequacy

The expected results for 2002-2003 were developed in collaboration with the WHO regions. Normative work was significantly strengthened, notably in the microbiology and biotechnology areas.

Budget adopted by the Health Assembly versus expenditure

The total budget adopted by the Health Assembly for the biennium was US$ 10 399 000 of which US$ 7 940 000 was recorded as expenditure. The bulk of funds not utilized relate to donations to the Codex Trust Fund, which will only become operational in 2004.

Total programme budget versus expenditure and expenditure by office (US$ thousand)

Area of work – programme budget	**10 399**
Area of work – expenditure	**7 940**

Expenditure by office:

Headquarters	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
5 837	241	460	151	332	135	784

Lessons learnt

- Coordination with the four key collaborators within WHO headquarters is required, as is continued strengthening of joint planning with the WHO regions.
- Expected results were not optimal and in several cases indicators were either not easily quantifiable or not directly relevant. Programme planning process could benefit from better joint understanding of the planning cycle between country offices, regions and headquarters. During the biennium, these cycles were not coordinated and, in most cases, not communicated.
- Although a strategic approach towards resource mobilization was developed, this requires further strengthening. Broader fund-raising activities should be pursued in 2004-2005.
- Specific outreach to country offices is necessary. More country-based work in the area of communication, training and data generation should be pursued in the next biennium.
- There needs to be a significant improvement in efforts to promote the use of normative work at regional and country levels.
- Better systems to interact with food safety authorities and in-country stakeholders are needed. There is also a need for better data and improved access to experts from developing countries.

EMERGENCY PREPAREDNESS AND RESPONSE

WHO objective(s)

To assure that Member States are better equipped to prevent and prepare for disasters and mitigate their health consequences, and create synergy between emergency measures and sustainable health development through appropriate coordination mechanisms and emergency response.

Summary of achievements

- Several initiatives at regional level, such as the resolution adopted in 2002 by the WHO Regional Committee for the Eastern Mediterranean,[1] confirmed the importance of WHO's role in disaster preparedness and response. Emergency preparedness and response position papers were also on the agendas of the regional committee meetings of the African and South-East Asia Regions held during the biennium. In the Western Pacific Region, increased collaboration with external partners led to a better recognition of the Organization's role in this field and an increased demand for WHO's intervention.
- Through the Department of health action in crises and other relevant departments, WHO increased its participation and technical contribution to interagency forums, such as the Executive Committee on Humanitarian Affairs and the Inter-Agency Standing Committee, in order to strengthen coordination of humanitarian assistance. During the period under review, WHO was represented in more than 30 interagency mechanisms and initiatives for emergency preparedness and response.
- WHO increased its work in this area at regional, subregional and country levels. The number of focal points for emergency and humanitarian action increased by 28%. WHO's presence was further strengthened by the opening of subregional offices for west Africa, southern Africa, the Great Lakes region and the Horn of Africa.
- The number of emergency response operations supported by WHO increased notably during the biennium, from 46 in 2002 to 122 in 2003.
- The Organization dedicated increased resources in support of countries adopting policies and systems to better prepare for and react to emergencies.
- Internal collaboration with technical departments at regional and headquarters levels increased in several areas, including training, production of technical guidelines and policy development.
- WHO expanded its training activities and collaboration with partners in developing, reviewing and providing material to international training programmes, such as Health Emergencies in Large Populations, United Nations Disaster Assessment and Coordination and Emergency Field Coordination Training.

Illustration of achievements at country, regional or global levels

- Three WHO humanitarian offices in the Balkans were successfully integrated into a "one WHO" office, combining humanitarian and development activities. Of a total of 28 country strategy health needs documents and biennial collaborative agreements, 12 included emergency preparedness and response as a strategic priority. An analysis of country cooperation strategy documents prepared by WHO showed that out of a total of 46 country cooperation strategy documents analysed, 18 specifically mentioned health in emergencies and humanitarian action among their concerns.
- Seven countries in the Eastern Mediterranean Region were provided with support for capacity-building activities for preparedness and mitigation. The Organization's capacity to respond to emergencies was enhanced; WHO's interventions in large humanitarian crises in Afghanistan, Islamic Republic of Iran, Iraq and the West Bank and Gaza Strip were evidence of this improvement.
- Technical departments and WHO Representatives in the WHO Region of the Americas continued to incorporate disaster management into their workplans and country offices in Brazil, Colombia, Cuba, Guatemala and Nicaragua assigned country funds for disaster management in all technical areas. *(continued on next page)*

[1] Regional Committee for the Eastern Mediterranean, resolution EM/RC49/R.7.

- An emergency management task force was established in the Regional Office for the Western Pacific in 2002.
- Examples of interregional achievements included the following: development by the Regional Offices for South-East Asia and the Western Pacific of a training programme for public health and emergency management for Asia and the Pacific, carried out in collaboration with other external partners; and collaboration between the Regional Office for the Americas and the Regional Office for the Western Pacific on training on the relief supply management system.

Achievement of expected results

Policy and advocacy positions to establish health as the object and yardstick of humanitarian action effectively promoted in appropriate forums and among relevant audiences

Indicator	Baseline	Target	Achievement
Evidence of countries adopting new policies in line with WHO's position	The production of country cooperation strategy documents started as a pilot project in 2000 and was only institutionalized in 2001[1]	To increase the number of country cooperation strategy documents including emergency and humanitarian action components	Of 46 country cooperation strategy documents analysed, 18 mentioned health in emergencies and humanitarian action among their concerns. In the WHO European Region, 12 out of 28 country strategy health needs and biennial collaborative agreements included emergency preparedness and response as strategic priority for collaboration. In Eastern Mediterranean Region, 7 countries addressed strategies for emergency preparedness and response
Number of policy documents issued by international committees and conferences on health and humanitarian action in which WHO participated[2]	2 policy papers presented to United Nations Economic and Social Council (ECOSOC); regular inputs to policy papers for the Executive Committee on Humanitarian Affairs (ECHA) and Inter-Agency Standing Committee (IASC); regular input to the annual report of the Secretary-General of the United Nations	To increase WHO's participation and input regarding policy documents on health and humanitarian action	4 policy papers presented to ECOSOC Humanitarian Affairs Segment; inputs to: IASC review, launch review of interagency Consolidated Appeal Process and unit review on internally displaced persons; regular inputs to ECHA and IASC policy papers; regular input to the Annual Report of the Secretary-General of the United Nations

[1] The country cooperation strategy is relied on as an indicator because it is discussed at ministerial level. So far, most of the country cooperation strategy documents developed are in the African, South-East Asia and Western Pacific Regions.

[2] Only policy documents at global level are considered; numerous other documents are produced and presented at regional forums.

Good-quality public health information tools and management systems developed and promoted, along both technical and operational lines, as basis for WHO leadership in improving preparedness and response and reducing vulnerability

Indicator	Baseline	Target	Achievement
Proportion of targeted country profiles including information for preparedness and vulnerability reduction	Information about 67 countries available on WHO web site for health action in crises; 1124 relevant documents posted (of which 1118 from WHO sources)	Number of relevant documents posted doubled on WHO web site for health action in crises	Information about 70 countries available on WHO web site for health action in crises; 2957 relevant documents posted (of which 1957 from WHO sources)
Evidence of WHO country budget allocated on the basis of vulnerability profile	The production of country cooperation strategy documents started as a pilot project in 2000, and was only institutionalized in 2001	Increase the number of country cooperation strategy documents including budget allocation for emergency preparedness and response	Of a total of 46 country cooperation strategy documents analysed, 10 included budget allocation for emergency preparedness and response.[1] In the European Region, of 28 country strategy health needs documents and biennial collaborative agreements, 12 will have funding for emergency preparedness and response. In the Region of the Americas, 5 country offices assigned country funds to disaster activities

Adequate political and technical support provided to institutionalized focal points in Member States and partners in order to prepare for and act appropriately in emergencies

Indicator	Baseline	Target	Achievement
Appropriateness of the presence and performance of focal points in WHO offices	52 trained WHO focal points for emergency and humanitarian action; 54 emergency response operations supported by headquarters	Double the number of staff trained	73 trained WHO focal points for emergency and humanitarian action; 122 emergency response operations supported by headquarters
Existence of memoranda of understanding for implementation of joint projects with partners at country level	5 memoranda of understanding existing before the biennium and a number of agreements for joint implementation at regional and country levels	To increase the number of memoranda of understanding and agreements with United Nations agencies and partners	3 new memoranda of understanding and a number of agreements for joint implementation of specific projects signed at regional and country levels

[1] Not all the country cooperation strategy documents contain a detailed budget breakdown.

International partnerships strengthened and resources mobilized in order to tackle health priorities for populations at risk of, or affected by, natural disasters and complex emergencies

Indicator	Baseline	Target	Achievement
Proportion of consolidated appeal processes including WHO component	100% of consolidated appeal processes included WHO component in 2001	100% of consolidated appeal processes including WHO component	100% of consolidated appeal processes included WHO component in 2003
Level of external resources mobilization in support of priorities identified by WHO	Level of funding achieved in 2001 14.8% of total appealed	To increase level of funding to 25% to 30% of total appealed	Level of funding achieved in 2003 29.1% of total appealed

Capacity of WHO to contribute effectively to disaster reduction strengthened through optimized management systems for staff and programmes

Indicator	Baseline	Target	Achievement
Patterns and distribution of recognized WHO disaster experts according to country vulnerability	52 WHO staff trained in disaster reduction in 6 regional offices, 11 suboffices and 30 country offices at beginning of 2002	Double the number of trained WHO staff at regional and country levels	73 WHO staff trained in disaster reduction in 6 regional offices, 11 suboffices and 51 country offices at end of 2003
Proportion of regional and country offices meeting the minimum requirement for operations	No standards for minimum requirement for operations agreed	Achievement of agreement over standards for operations	No agreement achieved but consultations reactivated with regional and country offices on definition of standards and levels of services to be provided. WHO Regional Office for the Western Pacific developed regional standards

Best public health practice in emergencies identified or updated, and promoted through appropriate publications and training programmes

Indicator	Baseline	Target	Achievement
Availability of guidelines and publications both electronically on the appropriate WHO web site and physically	Health Library for Disasters (HELID) containing 350 publications and documents related to health in emergencies – 2344 copies distributed in 2001; 44 Emergency Health Library Kits (EHLK) distributed in 2000-2001; the first version of the "Essentials for Emergencies" booklet was prepared in December 2001	Increase by 20% the number of publications and guidelines available in HELID; increase the distribution of HELID, EHLK and "Essentials for Emergencies" booklet	HELID containing 520 publications and reference documents (32% increase); 7553 copies distributed upon request (2000 to nongovernmental organizations, universities and partners), 47 EHLK distributed in the biennium; 2900 copies of "Essentials for Emergencies" booklet distributed in the biennium

Indicator	Baseline	Target	Achievement
Relevance of WHO support for changes in best practices	2 "lessons learnt" exercises carried out in the previous biennium with headquarters support and a number of evaluations at regional level	8 lessons learnt exercises carried out during the biennium, 4 each year	4 lessons learnt exercises supported by headquarters and at least 3 more documented and presented at regional level

Critical impediments

Internal: administrative and functional processes led to a delay in achieving Organization-wide consensus on the level of service to be provided by WHO in emergency preparedness and response. In addition, the number of staff available for work in this area, especially at country level, was very small in relation to the scope of activities to be undertaken.

External: regular funds were very limited for activities concerning health action in crises. As a result, the Organization relied heavily on extrabudgetary funds, which were largely earmarked for crisis-specific activities. The three-year programme is expected to overcome this obstacle through an alliance with key partners that will provide substantial core funding.

Internal and external: the formulation of a clear strategy and plan of action for emergency preparedness and response was not seen as a priority by many ministries of health; more must be done, therefore, to change this view.

Relevance and adequacy

Products, services and activities established in the programme budget were relevant to achieving the global expected results; some of the expected results were not fully achieved, however, largely owing to the lack of both stable, predictable funding and human resources. In order to overcome this, a process of strategic planning with the regions was initiated to streamline functions, levels of service and standard operating procedures for WHO's work in this area.

Budget adopted by the Health Assembly versus expenditure

Total expenditure (including the regular budget and other sources) for 2002-2003 was US$ 210 983 000, while the programme budget for 2002-2003 amounted to US$ 46 999 000. The significant difference between planned costs and actual expenditure was mainly due to two factors. First, when the programme budget was developed in 2000-2001, estimates for achievable targets were made very cautiously, focusing on the results of preceding bienniums without anticipating funds to be received for responding to major crises, especially in Afghanistan and Iraq. Secondly, the Department of health action in crises was requested to manage the Iraq oil-for-food programme, which did not form part of the workplan.

Despite the apparently high level of expenditure, it should be noted that emergency funds received were heavily earmarked for specific country responses and were time-limited, while the level of regular or stable funding for preparedness activities and core functions remained low, making it difficult to preserve the continuity of operations and establish long-term programmes.

Total programme budget versus expenditure and expenditure by office (US$ thousand)

Area of work – programme budget	**46 999**
Area of work – expenditure	**210 983**

Expenditure by office:

Headquarters	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
118 719	16 622	573	8 698	15 950	49 296	1 125

Lessons learnt

- The appointment of the Representative of the Director-General for Health Action in Crises reflected a strengthened commitment towards this area of work. During the following biennium, efforts were to be made to raise the visibility of WHO as a reliable partner in emergency preparedness and response and strengthen partnerships with United Nations organizations, donors, nongovernmental organizations and civil society.
- The strategic planning process that began in 2003 will be completed and the resulting plan implemented with the involvement of all levels of the Organization. More work is needed with technical departments, regional and country offices to consolidate the strategy for health action in crises at all levels and to streamline strategies and operations in general in order to enable WHO to provide leadership in this area. Mechanisms for implementing projects in line with the expected results will need to be strengthened at country and regional levels.
- Preparedness is a process that needs planning as well as country and organizational commitment and prior investment will be needed to prepare the Organization and its partners in the health sector if WHO's response at country level is to be entirely effective. Advocacy plans will therefore have to be developed to sensitize donors and attract additional funding.
- The early response phase of any emergency needs to be treated as a priority for which preferential channels and mechanisms must be defined within the Organization in order to avoid unnecessary administrative delays.
- To ensure a smooth transition from early response to the post-emergency, recovery and rehabilitation phases, attention should be given to long-term sustainable development activities during the post-emergency phase.
- The flow and timely use of information for well-informed decision-making and advocacy purposes should be strengthened to support WHO's comparative advantage as a provider of independent, evidence-based public health information.
- Partnerships with other United Nations agencies, nongovernmental organizations and other partners are being strengthened and institutionalized through memoranda of understanding and other types of agreement. At field level, regional and country offices will also be encouraged to widen partnerships.
- Further work is needed to define indicators that reflect regional priorities while maintaining a global perspective so that reporting on progress made against indicators can be done in a consolidated manner.

ESSENTIAL MEDICINES: ACCESS, QUALITY AND RATIONAL USE

WHO objective(s)

To create an environment enabling countries to increase significantly access to essential medicines by establishing, implementing and monitoring national drug policies and sustainable essential drugs programmes that ensure equity of access to essential drugs; drug quality, efficacy and safety; and rational use of drugs by health professionals and consumers; and focus on priority health problems and poor populations. To ensure appropriate integration of traditional medicine in health services.

Summary of achievements

- The WHO medicines strategy 2000-2003 was updated for the period 2004-2007 through a wide consultation process, involving staff at headquarters, regional and country offices, and more than 100 key external partners.
- A new prequalification programme for priority medicines was extended to cover medicines for tuberculosis and malaria as well as HIV/AIDS medicines; normative bases for starting prequalification of procurement agents and quality control laboratories were created and approved by the relevant expert committee.
- A strategy to support the safe and informed use of traditional and complementary medicines and protect the body of knowledge concerning traditional medicines was launched, with significant progress noted in the WHO African Region, Region of the Americas and Western Pacific Region.
- A global system was implemented for monitoring country-level progress in medicines through data collection and regional and national training (including the use of household surveys) in order to assess the affordability, availability, source, and appropriate use of medicines.
- Comprehensive guidance was provided at global, regional and national levels in relation to international trade agreements, including the implications of the Doha Declaration on Trade-Related Aspects of Intellectual Property Rights and Public Health.
- A campaign to raise awareness of the dangers of counterfeit and substandard medicines was launched and support provided to countries to fight the problem.
- The selection of essential medicines was revised to ensure a more evidence-based, independent, and transparent process.

Illustration of achievements at country, regional or global levels

- A network of 13 pharmaceutical advisers in country offices, including 11 in the African Region, was set up to serve WHO country offices in the area of essential medicines.
- Comprehensive training programmes were carried out in all regions on the following topics: good manufacturing practices, quality assurance and registration of essential drugs (especially antiretroviral agents), rational use of medicines by professionals and in-community, drug supply, pharmacoeconomics, and drugs and therapeutics.
- Information services on comparative medicine prices were expanded worldwide and a new survey methodology was launched and is now in use in many countries.[1]

Achievement of expected results

Adequate framework and models for implementing, and for monitoring the impact of, national drug policies promoted

Indicator	Baseline	Target	Achievement
Number of countries that have prepared, or updated in the past five years, a plan for implementing national drug policies	41 (39%) of 106 reporting countries	43%	49 (48%) of 103 reporting countries

[1] Medicine prices: a new approach to measurement. 2003 ed. (document WHO/EDM/PAR/2003.2).

Validated strategies and approaches based on evidence promoted for assuring affordability of drugs and financing from public and other sources

Indicator	Baseline	Target	Achievement
Number of countries in which annual public expenditure on drugs is less than US$ 2 per capita	38 (37%) of 103 reporting countries	35%	24 (30%) of 80 reporting countries
Number of countries which allow private pharmacies to substitute proprietary drugs with their generic equivalent	83 (61%) of 135 reporting countries	75%	99 (75%) of 132 reporting countries

Efficient systems for drug-supply management and traditional medicine validated and promoted in the public and private sectors

Indicator	Baseline	Target	Achievement
Number of countries that have public sector procurement based on a list of essential drugs	71 (53%) of 133 reporting countries	60%	84 (66%) of 127 reporting countries

Appropriate technical guidance and information, based on global standards, for safe use of pharmaceuticals and traditional medicines, disseminated and promoted

Indicator	Baseline	Target	Achievement
Number of countries participating in the WHO Certification Scheme on the Quality of Pharmaceuticals Moving in International Commerce	Not established	Not established	87 (64%) of 135 reporting countries

Instruments for cooperating with countries to create effective drug regulatory and quality assurance systems validated and promoted

Indicator	Baseline	Target	Achievement
Number of countries that have set up a basic drug regulatory system	70 (51%) of 138 reporting countries	56%	90 (69%) of 130 reporting countries
Number of countries that have basic quality-assurance procedures	95 (78%) of 122 reporting countries	80%	111 (81%) of 137 reporting countries
Number of countries with laws and regulations covering herbal medicines	48 countries	Not established	82 (65%) of 127 reporting countries

Global guidance and information on control and use of psychotropics and narcotics accessible at national and international levels

Indicator	Baseline	Target	Achievement
Number of substances reviewed and recommended for classification for international control	2 (66%) of 3 substances	Not established	5 (100%) of 5 substances

Framework promoted for implementing a national strategy to encourage, among professionals and consumers, rational and cost-effective use of therapeutically sound medicines, including traditional medicine

Indicator	Baseline	Target	Achievement
Number of countries that have a basic system for regulating pharmaceutical promotion	92 (70%) of 132 reporting countries	80%	83 (73%) of 113 reporting countries
Number of countries that have updated treatment guidelines in the past five years	60 (67%) of 90 reporting countries	70%	47 (62%) of 76 reporting countries

Critical impediments

Internal: staff-intensive policy work (e.g. WHO Essential Medicines Library and the Global Fund to Fight AIDS, Tuberculosis and Malaria) delayed other implementation activities. Staffing mismatches in some areas led to problems in service provision, such as having too few staff for country support. The decrease in regular budget funds caused a reduction in some normative activities and an increasing number of staff were switched from regular budget or unspecified funds to a specified source of funding. A decrease in central priorities for normative publications and the absence of revenue from sales cost the department an estimated additional US$ 500 000 for the production, editing and printing of documents. The activity management system is not a planning tool and the financial reporting tools used at headquarters are inadequate in so far as management and reporting requirements are concerned.

External: lobbying to further the commercial interests of certain parties within the pharmaceutical industry brought conflicting information into circulation in decision-making circles in WHO, deflecting the Organization from its mission to improve public health outcomes. The involvement of some Member States could also have been more consistent. Experiences with cooperation, networking and alliance building had varying degrees of success and the significant number of players involved made coordination increasingly complex and costly. Several regional offices, which were totally dependent on headquarters for extrabudgetary funding or which were expecting pledged funding that did not materialize, had to reduce a number of activities.

Relevance and adequacy

Achievement of the expected results continued to be relevant with the department expanding its work in the light of a dynamic global political and economic environment. Some expected results, however, were readjusted for 2004-2005. The WHO medicines strategy 2004-2007 and the new Programme budget 2004-2005 are now completely harmonized and in line with each other. The department's work is also highly relevant to implementation of the "3 by 5" strategy.

Budget adopted by the Health Assembly versus expenditure

The difference between the total programme budget and total expenditure was due to a shortage of both regular budget and extrabudgetary funds and the need to reserve a carry-over of funds for immediate implementation of activities at the beginning of the new biennium (50% of salaries and 25% of activities). Most of the activities for this area of work remained underfunded, particularly normative activities (such as updating the WHO Model List of Essential Medicines and making recommendations on pharmaceutical specifications), managing the prequalification project, providing guidance on the impact of international trade agreements on access to essential medicines, promoting the safety of medicines and running overall country and regional support activities.

Total programme budget versus expenditure and expenditure by office (US$ thousand)

Area of work – programme budget	**42 063**
Area of work – expenditure	**37 015**

Expenditure by office:

Headquarters	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
25 095	4 856	2 087	1 026	1 770	763	1 508

Lessons learnt

- Essential normative functions in the pharmaceutical field require better internal and external advocacy, combined with better understanding of the area of work on the part of senior WHO management.
- Regular contacts and meetings with regional offices (through, for example, the global medicines council) and with partners outside WHO (other United Nations system organizations and nongovernmental organizations) are vital for strong and effective collaboration.
- Joint staffing has proved to be an effective means of promoting cross-cluster collaboration.
- Setting up a network of national programme officers in the area of medicines requires regular follow-up and capacity building; however, it can be very effective in achieving additional results at country level.
- A combined system involving headquarters and regional offices is needed to monitor implementation of regional and country projects.

IMMUNIZATION AND VACCINE DEVELOPMENT

WHO objective(s)

To achieve substantial progress towards ensuring availability of new vaccines and biologicals, and immunization-related strategies and technology that will reduce the burden of diseases of public health importance; to strengthen the impact of immunization services as a component of health delivery systems; and to control, eliminate and eradicate priority diseases.

Summary of achievements

- The African AIDS Vaccine Programme was established with UNAIDS to promote HIV vaccine research and evaluation, regional and international collaboration, and the creation of national HIV vaccine plans. The Organization played a central role in establishing the Accelerated Development and Introduction Plan to assure the rapid access of countries to pneumococcal and rotavirus vaccines. The Measles Aerosol Project, aimed at developing and licensing a vaccine and a delivery device, was also successfully launched.
- Together with partners of the Global Alliance for Vaccines and Immunization, WHO worked with countries to expand the use of new and underutilized vaccines and 28 countries benefited from support in developing financial plans to ensure that progress was sustained.
- The number of Member States using vaccines of assured quality increased to 174 (91%) at the end of the biennium. By the end of 2003, 35% (67) of Member States had functioning monitoring and management systems for identifying and dealing with adverse events following immunization. These systems cover 62% of the global population under five years of age. Among developing countries, 62% (102) use auto-disable syringes for routine immunizations. In the African Region, they are used by 76% of Member States.
- The Reach Every District strategy was launched to improve access to immunization services and strengthen managerial capacity at the district level.
- By the end of 2003, poliomyelitis had been eliminated in all but six countries. The remaining countries in which the disease is endemic were Afghanistan, Egypt, India, Niger, Nigeria and Pakistan; India, Nigeria and Pakistan accounted for more than 90% of total cases. One of the main achievements during the biennium was the certification that the WHO European Region was free of poliomyelitis. This was the third region to be certified together with the Region of the Americas and the Western Pacific Region. WHO's poliomyelitis eradication programme published the *Global Polio Eradication Initiative: strategic plan 2004-2008*.[1]
- Reduction of measles mortality was documented in almost all regions, with the Eastern Mediterranean Region showing a 32% decrease, the African Region 21%, the South-East Asia Region 14% and the Western Pacific Region 10%. Indigenous transmission of measles was eliminated in the Region of the Americas. The countries in the European, Eastern Mediterranean and Western Pacific Regions established regional measles elimination goals.
- Progress continues to be made towards elimination of maternal and neonatal tetanus. Among 57 countries that had not achieved elimination at the baseline, five had provisionally done so by the end of the biennium and 29 had implemented the high-risk approach to accelerating elimination.

Illustration of achievements at country, regional or global levels

The near-achievement of poliomyelitis eradication demonstrates the firm commitment of all Member States, WHO regional offices and partners to this effort. In addition, the adoption of measles mortality reduction goals attests to the increased capacity of countries and regions to reduce childhood mortality. The African AIDS Vaccine Programme was established to promote HIV vaccine research through capacity building and collaboration at all levels.

[1] *Global Polio Eradication Initiative: strategic plan 2004-2008*. Geneva, World Health Organization, 2003.

Achievement of expected results

Research at the preclinical phase finalized for priority new vaccines or innovative delivery systems

Indicator	Baseline	Target	Achievement
Number of targeted candidate vaccines and vaccine delivery systems of public health importance that advance to Phase I clinical trials	4 for dengue vaccine; 4 for Japanese encephalitis; 2 for respiratory syncytial virus; 30 for HIV; 2 for cholera; 1 for *Shigella*; 1 for rotavirus	Phase I/II trials completed for tuberculosis, dengue (chimeric), measles (aerosol) and *Shigella* (ribosomal) vaccines; for Japanese encephalitis (chimeric), vaccine trial initiated in a developing country	5 for dengue vaccine (including 1 candidate vaccine for chimeric virus); 4 for Japanese encephalitis (including 1 vaccine for chimeric virus in Phase II trial); 3 for respiratory syncytial virus; 47 for HIV; 2 for cholera; 1 for *Shigella*; 1 for rotavirus; 2 for tuberculosis; 1 for measles (aerosol); 1 for malaria

Appropriate measures recommended for incorporation of pneumococcal and meningococcal conjugate vaccines and others into immunization programmes on the basis of clinical efficacy and effectiveness trials in developing countries

Indicator	Baseline	Target	Achievement
Number of targeted vaccines entering efficacy trials (Phase III) in a developing country where the disease is endemic	3 pneumococcal vaccines; 1 for enterotoxigenic *Escherichia coli* (ETEC); 1 for cholera; 2 for rotavirus; 1 for human papillomavirus; 1 for HIV; 1 for *Shigella*	Phase III trials completed for ETEC (inactivated oral), *Shigella* (oral live), cholera (Peru-15), and rotavirus (second generation vaccines). Phase III initiated for HIV (prime-boost)	3 pneumococcal vaccines; 1 for ETEC (inactivated oral); 1 for cholera (Peru-15); 1 for rotavirus (including 1 second-generation vaccine); 1 for human papillomavirus; 3 for HIV (including prime-boost combination); 1 for *Shigella*; 1 for respiratory syncytial virus (subunit vaccine)

Appropriate strategies promoted and support provided for accelerated introduction of underutilized vaccines, particularly hepatitis B and Hib [*Haemophilus influenzae* type b] vaccines

Indicator	Baseline	Target	Achievement
Proportion of countries that have introduced hepatitis B vaccine	116 (61%) of 191 countries introduced hepatitis B vaccine	Hepatitis B vaccine introduced in 190 (99%) of 192 countries	141 (73%) of 192 countries introduced hepatitis B vaccine
Proportion of countries that have introduced Hib vaccine	72 (38%) of 191 countries introduced Hib vaccine	Hib target not established	84 (44%) of 192 countries introduced Hib vaccine

Clinical trials of HIV candidate vaccines facilitated, including at least one Phase III efficacy trial; strategic plans for vaccine utilization developed

Indicator	Baseline	Target	Achievement
Number of developing countries that have prepared national plans or strategies for AIDS vaccines	3 (2%) of 164 developing Member States had national plans	3 additional African countries will develop national plans as part of the African AIDS Vaccine Programme	15 (9%) of 165 developing Member States have national plans; African AIDS Vaccine Programme launched
Number of trials of HIV candidate vaccines conducted in developing countries	17 trials conducted in 8 developing countries	3 additional trials initiated	27 trials conducted in 12 developing countries (including trial for prime-boost combination initiated in Thailand and an army trial in a country where disease endemic)

Updated or new guidance on the standardization and control of biologicals drawn up and promoted

Indicator	Baseline	Target	Achievement
Proportion of biologicals that have production and control recommendations consistent with latest scientific developments	Regulatory research was under way for 3 of 13 biologicals	Regulatory research completed for 13 priority biologicals by 2005	Regulatory research under way for 11 of 13 biologicals
Number of international biological reference materials used	1 of 14 biologicals had new or revised recommendations	New or revised recommendations completed for 14 priority biologicals by 2005	Recommendations being developed for 10 of 14 biologicals

Adequate support provided for framing policy and building up capacity to assure the quality of all vaccines delivered by national immunization services

Indicator	Baseline	Target	Achievement
Proportion of countries using vaccines of assured quality (as defined by WHO recommendations)	160 (83%) of 191 countries used vaccines of assured quality	192 (100%) countries using vaccines of assured quality	174 (91%) of 192 countries using vaccines of assured quality
Proportion of countries using vaccines monitored by vaccine vial monitors (VVMs), where relevant	82 (50%) of 164 countries that received recommendation from WHO used VVMs for oral poliovirus vaccine	165 (100%) countries that received recommendation from WHO using VVMs	82 (50%) of 165 countries that received recommendation from WHO using VVMs. In addition to oral poliovirus vaccine, VVMs used for BCG vaccine for tuberculosis, diphtheria-tetanus-pertussis, tetanus toxoid, measles, yellow fever and hepatitis B vaccines

Adequate support provided for building up capacity in priority countries to implement a comprehensive system that ensures safe injection practices

Indicator	Baseline	Target	Achievement
Proportion of targeted countries implementing satisfactory safe-injection practices as defined by WHO standardized survey	36 (22%) of 164 middle- and low-income Member States implemented safe-injection practices	132 (80%) of 165 middle- and low-income Member States implementing safe-injection practices	37 (22%) of 165 targeted countries implementing safe-injection practices
Percentage of targeted countries monitoring the safe collection and destruction of syringes used for vaccination	Not established	165 (100%) of 165 middle- and low-income Member States introduce auto-disable syringes	102 (62%) of 165 targeted countries using auto-disable syringes. Better estimates achieved through collaboration with UNICEF (data cannot be compared to the baseline owing to use of different estimation base data)

Adequate technical and policy support provided to priority countries in order to strengthen key immunization functions and managerial capability in public health at national and district levels

Indicator	Baseline	Target	Achievement
Percentage of districts in priority countries with at least 80% coverage of triple dose diphtheria-tetanus-pertussis vaccine	26 (16%) of 164 developing Member States had all districts with at least 80% coverage of triple dose diphtheria-tetanus-pertussis vaccine (DTP-3)	41 (25%) of 165 developing Member States having all districts with at least 80% DTP-3 coverage	43 (26%) of 165 developing Member States had all districts with at least 80% DTP-3 coverage

Effective coordination and support provided for eradication of poliomyelitis and certification of all WHO regions as free of poliomyelitis

Indicator	Baseline	Target	Achievement
Number of WHO regions certified as free of poliomyelitis	2 of 6 WHO regions certified as free of poliomyelitis	All 6 WHO regions certified free of poliomyelitis by 2005 WHO European Region certified free of poliomyelitis by 2002	3 of 6 WHO regions (including the European Region) certified free of poliomyelitis Poliomyelitis eliminated in all but 6 countries in the world

Adequate support provided for building up capacity in priority countries to implement strategies for controlling and eliminating major vaccine-preventable diseases

Indicator	Baseline	Target	Achievement
Percentage of countries implementing the high-risk approach to accelerating elimination of maternal and neonatal tetanus	15 (26%) of 57 countries that have not achieved goal for elimination of maternal and neonatal tetanus implemented high-risk approach	7 (12%) of 57 countries provisionally achieved goal for elimination of maternal and neonatal tetanus	5 (9%) of 57 countries have provisionally achieved goal for elimination of maternal and neonatal tetanus; 29 (51%) of 57 countries that have not achieved goal implemented high-risk approach
Percentage of countries implementing strategies for accelerated measles control	140 (73%) of 191 countries offered second opportunity for immunization	192 (100%) countries implementing accelerated measles control strategies	163 (85%) of 192 countries offered second opportunity for measles immunization
Percentage of countries where vitamin A deficiency is a public health problem that have integrated vitamin A supplementation with immunization services	76 (56%) of 135 countries with vitamin A deficiency integrated vitamin A supplementation with immunization services	Goal for elimination of vitamin A deficiency achieved by 2010. By then, all 136 targeted countries should have vitamin A supplementation integrated with their immunization services	80 (59%) of 136 countries with vitamin A deficiency integrated vitamin A supplementation with immunization services

Critical impediments

External: establishing partnerships at global, regional and country levels is critical to ensuring that the countries that are most in need are targeted for increased support. An acute funding crisis in early 2003 led to a complete revision of the tactical approach for poliomyelitis eradication, beyond the limits of original contingency plans, putting the programme at substantial risk.

Internal and external: field staff lacked adequate training and financial support, which hampered efforts to increase management capacity at district level. Lack of political commitment towards decentralization in countries adversely affected WHO's work to ensure the safe provision of immunization services through improved programme performance. This was especially true for efforts to eradicate poliomyelitis. Shortfalls in vaccine supply seriously hindered efforts to increase vaccine coverage. Poor disease surveillance systems and lack of good management information systems delayed not only the introduction of new vaccines but also the improvement of the decision-making processes. The shortfall of funds to support countries remained a critical impediment to reaching the goal of poliomyelitis eradication.

Relevance and adequacy

The relevance of expected results within this area of work was highlighted by the following successes: progress made in bringing the eradication of poliomyelitis very close; the reduction achieved in measles mortality; improvements made in the provision of immunization services; global progress in the use of vaccines of assured quality; and the introduction of new vaccines, resulting from basic research efforts.

Budget adopted by the Health Assembly versus expenditure

The budget established at the beginning of the biennium amounted to US$ 184 692 000. During the early phase of implementation, this budget was increased to US$ 419 424 000, based on actual resources made available. Total expenditure for the biennium was US$ 401 286 000.

Total programme budget versus expenditure and expenditure by office (US$ thousand)

Area of work – programme budget	**184 692**
Area of work – expenditure	**401 286**

Expenditure by office:

Headquarters	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
82 083	172 139	3 148	57 141	9 109	64 557	13 109

Lessons learnt

- Maintaining WHO's technical excellence is critical for establishing policy, standards and norms, as well as guiding partnerships to support immunization goals. For this reason, it is crucial that regional offices receive support to improve their capacity for monitoring progress.
- Close collaboration with regional offices, countries and partners is essential for enabling the Organization to mount an appropriate response to unexpected events.
- Successful country-level performance requires detailed annual national plans of action with adequate budgetary support for carrying out activities, maintaining high vaccine coverage in all districts and managing unexpected events.
- Augmenting national capacity to take advantage of innovations and technologies for vaccines will require constant, high-quality technical support from WHO.
- Increasing impact at country and district levels requires greater participation by communities in programme advocacy and implementation.

BLOOD SAFETY AND CLINICAL TECHNOLOGY

WHO objective(s)

To assure that Member States are equipped to improve access of the population to safe blood, blood products and health-care technologies, and to promote good-quality health care services that are supported by safe and cost-effective technologies.

Summary of achievements

- Appropriate support was provided to enable countries to establish national blood safety programmes using the global database on blood safety, 2000-2001. Collaboration and partnerships with organizations working in global blood safety were strengthened, and regional as well as national capacity building were carried out for quality management systems in blood transfusion services.
- New biological standards were prepared on existing, new and emerging technologies. These included the development of tissue infectivity categories for prion agents, in both human and animal tissues. These categories established themselves as an essential tool in the risk assessment regulations of pharmaceutical and biological products involving bovine and human-derived products.
- Diagnostic support for the diagnosis and management of HIV infection was improved, and the quality and safety of general diagnostic imaging services were enhanced.
- Separate projects on blood cold chain equipment, injection safety and medical device regulations were integrated into a core strategy for medical devices.

Illustration of achievements at country, regional or global levels

- There were significant achievements in strengthening collaboration and partnerships in global blood safety. The WHO-convened forum, the Global Collaboration for Blood Safety, held its third and fourth meetings with the involvement of all stakeholders.
- Institutional capacity building and human resource development were supported by identification and strengthening of regional quality training centres and organization of structured training courses. As part of the global quality management programme for blood transfusion safety, 18-day training courses continued through the biennium in the WHO regions, with support from national blood transfusion services.
- In some of the target countries, including Burkina Faso, China and Sri Lanka, appropriate support was provided in establishing national blood safety programmes.

Achievement of expected results

Global collaboration set up, leading to consensus on effective strategies to improve access to safe blood transfusions and injections

Indicator	Baseline	Target	Achievement
Technically sound consensus statements on global blood safety through global collaboration for blood safety	Consensus statement on good policy practice and blood transfusion services initiated through bilateral and multilateral collaboration and partnerships with several organizations and institutions working on global blood safety	Develop consensus statements and products on all relevant issues as tools for countries to improve policies and practice through cooperative partnership, addressing the problems in global blood safety	Draft consensus statement developed on good policy practice; draft minimum requirements established for blood transfusion services Global awareness and advocacy on blood safety issues enhanced and identification of blood safety as priority issue for countries facilitated through strengthened global collaboration

Indicator	Baseline	Target	Achievement
Proportion of targeted countries implementing effective policies and plans for safe and appropriate use of injections	23 countries having conducted an initial assessment using new WHO methods	60 countries completed initial assessment; 6 conducted planning workshops; 14 implementing activities	63 countries completed initial assessment; 11 conducted planning workshops; 14 implementing activities

Advice and models provided for establishing systems that improve access and use in the areas of transfusion therapy, diagnostic imaging, clinical laboratory services and medical devices

Indicator	Baseline	Target	Achievement
Proportion of targeted countries with documented uninterrupted access to safe blood transfusion therapy in all main hospitals	1999 estimates indicate that 120 (66%) of 180 countries have access to safe blood	Establishment of blood safety programmes in all (100%) countries	National blood policies and plans established in 145 (81%) of 178 countries
Proportion of targeted countries with good laboratory and radiological practices, equipment management and disposal of health care waste	Catalogue prices of test kits Improved access gained to high-quality diagnostics through negotiated prices	WHO bulk procurement scheme expanded to include HIV and hepatitis B and C tests in order to reduce costs by at least 30%	Costs for diagnostic tests reduced, on average by 40%. 32 countries and 4 United Nations agencies used the scheme
	WHO guidance on basic laboratory techniques, adequate diagnostic imaging services and specific HIV/AIDS laboratory aspects (including biosafety, quality assurance and equipment maintenance)	Second edition of *Manual of basic techniques for a health laboratory* printed in December 2003[1]	Second edition of the *Manual of basic techniques for a health laboratory* available through WHO
	Lack of trained medical staff especially in small and medium-size hospitals in remote locations in countries with poor economy	2 new medical manuals	WHO diagnostic imaging manual published[2] Manuscript on preventive and routine maintenance of radiographic equipment finalized CD-ROM on WHO lecture series on radiology and ultrasound adapted to needs in developing countries Centre of excellence for continuing education in diagnostic imaging established in Fiji

[1] *Manual of basic techniques for a health laboratory,* 2nd ed. Geneva, World Health Organization, 2003.

[2] Sandström S. *The WHO manual of diagnostic imaging: radiographic technique and projections.* Geneva, World Health Organization, 2003.

Indicator	Baseline	Target	Achievement
	General WHO guidance on medical devices	Support provided to 2 countries with the essential health-care technology package software	Support provided to Mozambique and South Africa; initial assessment made in China

Validated norms, standards and biological reference preparations produced and access assured to external quality-assessment schemes

Indicator	Baseline	Target	Achievement
Number of international biological reference preparations, guidelines and recommendations produced and available as established by the Expert Committee on Biological Standardization	Reference materials applied to the standardization of blood products and in vitro biological diagnostic procedures, as cited in the catalogue of WHO biological reference materials 4 WHO guidelines applied to blood products and in vitro biological diagnostic procedures, adopted by the Expert Committee on Biological Standardization 2 aide-memoires issued, on national regulatory authorities and on quality and safety of blood products, together with 2 information sheets for plasma contract fractionation facilities (and responsibilities of national regulatory authorities in this context)	Development and establishment of between 10 and 20 reference materials and 1 or 2 guidelines Research, development and evaluation of new technologies and methods	18 reference materials developed and established by the WHO Expert Committee on Biological Standardization 1 new guideline adopted on transmissible spongiform encephalopathies (in relation to blood-derived products and other pharmaceutical products)

Indicator	Baseline	Target	Achievement
Number and performance of institutions participating in WHO external quality-assessment schemes	Several external quality-assessment schemes covering different disciplines, including infectious diseases, immuno-phenotyping, haematology, blood group serology, coagulation, biochemistry and parasitology	Depending on the scheme, between 1 and 6 distributions issued per annum, and assistance provided to establish and/or strengthen national schemes. Target performance rate for each of the schemes should be at least 80%	WHO schemes had over 700 participants. Performance rates varied widely between schemes, from 48% (parasitology) to 97% (HIV serology). 5 national external quality-assessment schemes established and/or strengthened

Validated material and models available for improving knowledge and skills in blood transfusion medicine and clinical technology, leading to a reduction of associated risk in targeted populations

Indicator	Baseline	Target	Achievement
Increase in the use of WHO training materials, guidelines and recommendations for reducing risk associated with blood transfusion	Technical support provided to several countries on development of national blood safety programmes	Development and implementation of nationally coordinated blood transfusion services with quality systems	Effective tools and mechanism developed to assist countries to develop standards, and assess, plan, implement and evaluate their blood safety programmes
Proportion of targeted countries having received adequate guidance and support for evaluation and control of blood products and related biologicals	Technical assistance provided to all regulatory authorities in Member States and to WHO regional offices requesting support (Regional offices for the Americas, Europe, the Eastern Mediterranean and the Western Pacific) A workshop on blood products safety held for 50 countries representing the 6 WHO regions	Development and implementation of national quality systems	Guidelines, recommendations and international reference materials made available to countries

Critical impediments

Internal: a lack of financial and human resources limited the work. For example, there was a demand for support to be provided on regulatory systems for blood products and medical devices, but only limited work could be done.

External: there was a lack of nationally coordinated approaches to surveillance and health technology delivery, including blood transfusion.

Relevance and adequacy

Expected results for this area of work were largely adequate in relation to the achievement of the WHO objective, reflecting a strong focus on building country-level capacity for blood transfusion safety.

Budget adopted by the Health Assembly versus expenditure

The total expenditure incurred in 2002-2003 from both the regular budget and other sources, was US$ 15 748 000 against the programme budget of US$ 25 727 000 for the same period.

Total programme budget versus expenditure and expenditure by office (US$ thousand)

Area of work – programme budget	**25 727**
Area of work – expenditure	**15 748**

Expenditure by office:

Headquarters	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
10 494	1 624	502	1 159	443	570	956

Lessons learnt

- Success was achieved when expected results were driven by country needs. This was particularly the case in expanding the scope of work to address more health technologies. The two key challenges will be the clarification of the respective roles of headquarters, regional and country offices, and the development of a strong network across all WHO offices to achieve the desired expected results.
- Government commitment had a significant influence on efforts to achieve some of the expected results. National authorities should, therefore, be involved in the process from the outset.
- There is an urgent need to form regional regulatory networks in order to ensure the implementation of good manufacturing practices and other regulatory systems to protect the quality and safety of blood products and related biologicals.
- There is increasing concern over blood donor numbers and the need to preserve a stable base of regular, voluntary nonremunerated donors; strategies for identifying and retaining low-risk blood donors therefore need to be developed urgently. Strengthening national coordination is another significant issue for many blood transfusion services, calling for high-level management initiatives and political commitment.
- It is necessary to work with the relevant operational departments in countries to improve sustainability and long-term impact and to ensure the collaboration of other institutions, both international and local.
- The strong focus on blood transfusion safety was to some extent achieved at the expense of other health technologies. The proper functioning of health systems depends on equal emphasis being placed on all technologies.

EVIDENCE FOR HEALTH POLICY

WHO objective(s)

To improve performance of health systems by the generation and dissemination of evidence, and to provide support for international and national dialogue on health policy.

Summary of achievements

- The framework for assessing health system development was further improved through the work of a scientific peer review group. Considerable attention was paid to assessing the key functions of health systems and how they can be used to improve outcomes, particularly for stewardship and financing.
- Frameworks and methods were developed for global, regional and national burden of disease analysis, costing and cost-effectiveness, and measurement of both health system responsiveness and the impact of the financing system on catastrophic payments and poverty.
- Formal networks were established in three WHO regions on national health accounts and a producer's guide was published in collaboration with the World Bank and the United States Agency for International Development.[1] Support was given through regional workshops to enable countries to implement national health accounts.
- The World Health Survey instrument was finalized and implemented by 73 Member States after extensive testing and revision.
- Training packages were developed following the approval of the International Classification of Functioning, Disability and Health (ICF). Training and reference centres for the WHO family of international classifications now include ICF as part of their portfolio.
- Country-level burden of disease studies were undertaken in the Gulf States and in the WHO South-East Asia Region. In addition, country-costing studies were undertaken in over 14 countries and cost-effectiveness tests of a country tool were undertaken in one country. Countries were supported in policy development for health financing and social and community-based insurance and contracting. For the first time, national teams received training on data analysis and policy development in relation to health and poverty.
- Five countries requested and received support to undertake subnational health system performance assessments. In Kyrgyzstan, the WHO framework was adapted at country level and used for organizing reports to the Government and donors on health system performance and the effects of reforms.

Illustration of achievements at country, regional or global levels

- All regions continued to provide support for strengthening health information and vital registration systems. For example, in the European Region, implementation of the tenth revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) was expanded to an additional six countries (covering 82% of the Region).
- In the Eastern Mediterranean Region, support was provided to two countries to review their health information systems, two further countries were given support to strengthen the use of ICD-10; technical support to strengthen health statistics capacity was provided to another country, and an intercountry workshop on the use of informatics tools in health information systems was held. Most countries in the South-East Asia Region completed assessments of their health information systems with a view to strengthening them.

[1] *Guide to producing national health accounts: with special applications for low-income and middle-income countries.* Geneva, World Health Organization, 2003.

Achievement of expected results

Consistent, ethical, evidence-based policy recommendations available on health care financing, sector-wide and intersectoral approaches to health development, and efficient mixes of interventions

Indicator	Baseline	Target	Achievement
Use in countries and regions of WHO policy recommendations on health care financing, sector-wide and intersectoral approaches to health development and mixes of interventions	Not established	Not established	At least 14 countries undertook costing studies for assessing mixes of interventions; another 20 received input on financing options and approaches to poverty alleviation 18 country profiles on health care systems in transition completed

Operational mechanisms and validated tools available for updating information regularly and facilitating routine analysis of health system performance; strategies and policies formulated to improve performance of health systems

Indicator	Baseline	Target	Achievement
Availability of pretested tools for routinely assessing health system performance	Not established	Not established	Pretested tools made available for national health accounts, burden of disease assessment, costing and cost-effectiveness; survey instruments finalized; a new tool for policy-makers developed and introduced, namely, the European Region's rapidly expanding health evidence network project, providing responses to policy-makers' questions on interventions for public health
Methods of measuring and improving performance identified in selected countries, in collaboration with regional offices	Not established	Not established	Subnational performance assessment commenced in 4 countries. More than 100 others introduced components of framework

Validated framework, based on agreed methods and indicators, drawn up for improving capacity to obtain, analyse and use key information, including on population health, valuation of health states, risk factors, cost-effectiveness analysis, and analysis of the economic cost of illness

Indicator	Baseline	Target	Achievement
Availability of indicators and methods of obtaining key public health information on the basis of WHO's framework	Not established	Not established	Methods developed in relation to the above tools, as well as for health financing, resource generation and stewardship functions
Framework adapted to health policy-making in selected countries on the basis of Organization-wide collaboration	Not established	Not established	Framework adapted to include more focus on functions of health systems following consultations in each region and deliberations of a scientific peer review group of outside experts from all six WHO regions Some regions continue to produce regular health situation reports (e.g. *The European health report*, appearing every 3 years)

Networks and partnerships in operation for epidemiological estimates and methods, economic analysis, policy analysis, measurement of health system performance (both for goals and functions), gender analysis, and ethics

Indicator	Baseline	Target	Achievement
Representation of regions and national institutions in working networks for methods of obtaining estimates on key health policy parameters	Not established	Not established	Networks established with regional and country participation on burden of disease, cost-effectiveness and national health accounts. International collaboration continued on international classifications, involving collaborating centres and some regions. Up-to-date health data and information from the Regional Office for Europe's European health for all database and the South-East Asia Region's country health profiles enabled productive collaboration with countries and offered possibility of international comparisons 1 country in the South-East Asia Region conducted a subnational health system performance assessment

Norms, standards, terminology and methods determined and validated on key issues, including population health and its measurement, analysis of economic efficiency, economic cost, ethical implications of resource allocation and national health accounts in developing countries

Indicator	Baseline	Target	Achievement
Availability of selected norms, standards, terminology and methods to meet priority needs of countries and regions for producing evidence on which to base health policy, and their use in selected countries	Not established	Not established	Guidelines for production of clinical guidelines developed for use within WHO; cost-effectiveness guidelines finalized;[1] standards for undertaking national health accounts published in the producers' guide together with standards for measuring and interpreting catastrophic payments; common instruments for health interview surveys in the European Region developed and published[2]

[1] *Making choices in health: WHO guide to cost-effectiveness analysis.* Geneva, World Health Organization, 2003.

[2] Nossikov A, Gudex C, eds. *EUROHIS: developing common instruments for health surveys.* Copenhagen, WHO Regional Office for Europe, 2003.

Practical tools for policy-makers designed and validated in key areas, including analysis of the burden of disease and projections, preparation of recommendations on evidence-based best practice, assessment of alternative ways of improving health system performance, and management of change in health systems

Indicator	Baseline	Target	Achievement
Availability of selected practical tools for policy-makers to use in national policy planning within WHO's framework	Not established	Not established	Practical tools made available on costing, cost-effectiveness analysis, burden of disease assessment, national health accounts, and international classifications such as the ICF and ICD-10. The Regional Office for South-East Asia tested tools to obtain an adequate sample of cause of death certifications
Incorporation of these tools in health policy-making in selected countries on the basis of Organization-wide collaboration	Not established	Not established	Regional workshops held and technical support provided to countries on the following matters: costs, burden of disease assessment, performance assessment, national health accounts, and the use of ICD-10

Critical impediments

Internal: financial restrictions hampered implementation of workplans in some regions. In others, staff shortages were reported. Some bilateral donors considered that the area fell within the scope of WHO's core functions and was therefore inappropriate for specified extrabudgetary funding.

External: some countries wished to advance on key areas covered by this area of work with greater speed than could be supported by WHO at country, regional or headquarters levels.

Relevance and adequacy

The area of work is crucial to health system development, however, achievements were limited by the lack of skilled technical staff.

Budget adopted by the Health Assembly versus expenditure

Expenditure was 95.9% of the programme budget.

Total programme budget versus expenditure and expenditure by office (US$ thousand)

Area of work – programme budget	**43 225**
Area of work – expenditure	**41 447**

Expenditure by office:

Headquarters	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
25 620	1 065	1 336	1 349	9 669	945	1 463

Lessons learnt

- Provision of evidence for health policy is central to the development of appropriate health systems, the proper functioning of which is itself vital to the success of disease-specific programmes.
- Information needs to be tailored to the needs and capacities of countries.
- If country activities are to address priority needs, close planning and coordination between headquarters and the regions are required so that a coherent approach can be ensured.
- Organizational support and capacity for health information system development need strengthening both in WHO and in countries.
- It is difficult to attract specified extrabudgetary contributions for this activity as many donors imagine that it is a core WHO activity. It will be necessary to encourage donors to invest more in this international public good as the involvement of high-quality experts is directly linked to adequate operational budgets.

HEALTH INFORMATION MANAGEMENT AND DISSEMINATION

WHO objective(s)

To facilitate access of governments, WHO's partners in health and development, and staff to reliable, up-to-date health information that is based on evidence and provides guidance for establishing health policy and practice both nationally and internationally.

Summary of achievements

- As part of the substantial Organization-wide contributions made to achieving the expected results, access to published information was expanded at regional and country levels through both electronic and traditional means.
- Norms, standards and policies were established for all web work across the Organization.
- The global information full-text initiative was introduced worldwide to all WHO staff.

Illustration of achievements at country, regional or global levels

- For the first time, WHO staff in headquarters, regional and country offices had access to over 1000 scientific journals and major databases.
- Two interregional meetings were held, bringing together publishing and library sciences experts from across the Organization.

Achievement of expected results

Organization-wide health information strategy and policy in operation to guide staff in their work

Indicator	Baseline	Target	Achievement
Impact of the Organization-wide strategy and policy on health information on the practice of staff	The publications office at headquarters, in consultation with the regional offices, continued to promote editorial standards throughout the Organization in 2002-2003 through the development, updating and dissemination of writing and editing guidelines	Global	The WHO style guide was finalized and issued[1] Guidelines on outsourcing work to freelance editors and on editing for WHO finalized and made available in electronic form on the Organization's Intranet Writing and editing guidelines on the Intranet updated and reorganized to make site more user-friendly; links added to related content Advisory role on writing and editing matters expanded, through a combination of personal consultations and staff briefings

[1] WHO style guide (document WHO/IMD/PUB/04.1).

Indicator	Baseline	Target	Achievement
			Briefings on house style and on outsourcing work to freelance editors developed and presented to some 200 in-house staff Advice provided on suitable freelance editors, writers, proofreaders and indexers for specific information products Major effort made to expand and provide advice on the directory of freelance editors, writers, proofreaders and indexers provided by the Department of health information management and dissemination

Identification of target audiences and their needs improved, and relevant information in a range of languages and form delivered more effectively in various media

Indicator	Baseline	Target	Achievement
Increased use by target audiences of WHO's web site	During 2003, there was a monthly average of 3 250 000 visitors accessing information on the WHO web site	Global	Advances recorded in each of main areas: editorial, design, client services and support, and publishing. Tools norms, standards and policies established for all web work across Organization
Frequency and volume of requests for use of WHO copyright material	An estimated 750 000 copies of translated editions of WHO information materials to reach readers in 66 languages	Global	Group responsible for copyright and licensing concluded a total of 381 contracts for publication of translations of WHO information materials and arranged 39 agreements for reprinting WHO books, totalling some 35 000 copies Arrangements made with 3 specialist publishers for joint marketing of books in English Some 5000 requests to reproduce extracts from WHO journals, books, documents and web pages answered Agreement concluded with the Copyright Clearance Center in the United States and discussions in progress with representatives of the International Federation of Reproduction Rights Organisations

Processes and mechanisms improved for the planning, development and dissemination of health information products, including introduction of a document management system and periodic evaluation and refinement

Indicator	Baseline	Target	Achievement
Access throughout the Organization to well organized information on WHO's health information materials, particularly in electronic form	A set of electronic tools for workflow, enterprise content management and reporting were developed to implement the single process (re-engineered in 1999-2000) for the planning, development, production, dissemination and evaluation of all health information products	Global	In order to support WHO staff in the delivery of high-quality, timely, accurate health information, 2 sites developed on WHO Intranet in support of its process and service delivery: http://intranet.who.int/homes/pps for publishing process support and http://intranet.who.int/homes/imd for health information management and dissemination Continued improvements in new generation of promotion tools for marketing and dissemination introduced and functionalities of publications web site improved to include e-commerce; multilingual presentation of information provided; mix of both free and sales products put in place; and continued improvement ensured of such features as the "Book of the Month" announcement WHO publications exhibited at book fairs, meetings and professional congresses throughout the world Steps taken to continue introduction of common information dissemination and communication strategy despite limited financial resources

Selected priority information products, including *The world health report*, the *Bulletin of the World Health Organization*, and regional journals appropriately promoted, marketed and disseminated in relevant languages

Indicator	Baseline	Target	Achievement
Availability of selected information products in relevant languages in high-priority countries	*The world health report 2002* was published in English, French and Spanish;[1] summary versions in Arabic, Chinese and Russian were published simultaneously on the WHO web site;[2] *The world health report 2003* was published in English, French and Spanish editions.[3] An Arabic edition was produced by the Regional Office for the Eastern Mediterranean[4] 2 volumes of the *Bulletin of the World Health Organization* were published both in print and online,[5] containing 24 issues	Global	*The world health report 2002* was one of the largest research projects ever coordinated by WHO, identifying the leading 20 risk factors responsible for about half of all global mortality and assessing the cost-effectiveness of measures to reduce them *The world health report 2003* had additional supporting materials, including a CD-ROM with a comprehensive PowerPoint presentation. This was particularly intended for, and appreciated by, WHO country representatives, several of whom used it as the basis for launching the report in their country of work The impact factor of the *Bulletin of the World Health Organization* nearly doubled over recent years, from 1.43 in 1998 to 2.69 in 2002. There was also a significant increase in the citation rate (total citations in 2003: 4265). At the end of the biennium, the *Bulletin of the World Health Organization* ranked among the top 10 public health journals in both categories

[1] *The world health report 2002. Reducing risks, promoting healthy life.* Geneva, World Health Organization, 2002.

[2] Available at http://www.who.int/whr/2003/en.

[3] *The world health report 2003. Shaping the future.* Geneva, World Health Organization, 2003.

[4] *The world health report 2003. Shaping the future.* (Arabic version.) Geneva, World Health Organization, 2003.

[5] *Bulletin of the World Health Organization,* 2002, 80; *Bulletin of the World Health Organization,* 2003, 81.

Management and sharing of information improved throughout the Organization, including that designed for dissemination outside WHO; better access of staff in all geographic locations to the information they need to carry out their work effectively

Indicator	Baseline	Target	Achievement
Satisfaction of staff in different geographic locations with the information support needed for their work	The WHO library database, WHOLIS, continued to serve as the basis of the Organization's collective memory by recording and providing full-text access to all WHO material produced across the Organization	Global	WHOLIS accelerated its drive to link full-text records of current publications, technical documents and out-of-print publications and evolved from a bibliographical to a full-text repository, for users around the globe The WHO global information full-text initiative introduced to all WHO staff as an Organization-wide service For the first time, WHO staff in regional offices, country offices and headquarters had access to over 1000 scientific journals and major databases, through a package negotiated by the Department of library and information networks for knowledge on behalf of the whole of the Organization; library at headquarters also provided health topics for WHO web site, as well as cataloguing in publication for every WHO monograph published WHO library expanded its core services by providing individual in-depth research services to technical units and in supplying instant, up-to-the-minute scientific background material to teams working on severe acute respiratory syndrome, and avian influenza Training sessions conducted on a daily and weekly basis for WHO staff, and training modules produced on CD-ROM for the regional offices

"One WHO" web site in operation, providing, with easy navigation, reliable and up-to-date information to meet the needs of both developing and developed country users, and making best use of available technology

Indicator	Baseline	Target	Achievement
Increased percentage of WHO information on "one WHO" web site, generated from a standard set of templates that meet the policy criteria for health information	Norms, standards and policies established for all web work across the Organization		In July 2002, project launched to redesign web site; information architecture improved and sophisticated content management toolsets implemented, enabling departments to develop and publish their own content within context of overall WHO web site In December 2002, full-scale training programme made available to all staff members on many aspects of web publishing. To date, over 250 users have been trained at no expense to trainees or their units

Indicator	Baseline	Target	Achievement
Increased frequency of updates to content of the WHO web site, without broken links	The number of content providers at headquarters more than tripled as a result of the extensive training programme and client services	Global	There are currently a number of large-scale projects under way to prepare for fundamental changes in the way information is organized and published on the site, together with a broadening of the type of content available and an increase in the number of languages in which it is expressed

Critical impediments

Internal: the most significant critical impediment was lack of sufficient funding both in headquarters and regional offices, which resulted in the deferral or cancellation of certain activities. In headquarters this was due, in part, to the fact that the Department of health information management and dissemination was developing new unfunded areas.

External: there was a lack of interest from external funders in internal critical service provision.

Internal and external: positioning WHO's knowledge management assets in a more proactive and integrative framework required a change in institutional culture.

Relevance and adequacy

Demand for the services provided was high in regions and in countries – a clear indication of the relevance and adequacy of the activities of this area of work throughout the Organization.

Budget adopted by the Health Assembly versus expenditure

Total programme budget versus expenditure and expenditure by office (US$ thousand)

Area of work – programme budget	**46 370**
Area of work – expenditure	**39 506**

Expenditure by office:

Headquarters	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
23 782	4 195	2 068	1 173	4 804	1 968	1 516

Lessons learnt

- Operational planning should be tightly linked to financial and human resource planning; however, the planning process was hampered by uncertainty about the budget alterations at the beginning of the biennium.
- WHO does not have an effective mechanism to fund and manage cross-cutting activities that are not purely administrative.
- WHO's formal selection process through Request for Proposals and its focus on fixed-priced bids can be detrimental in the long run for effective outsourcing of software engineering projects, as there is no easy way to manage an iterative development – and therefore an iterative cost model – on a large scale, although it is these that are, in fact, most needed. If the bidding evaluation mechanism cannot be modernized for this type of activity it would be preferable to issue a Request for Information first and then conduct analysis, development and quality assurance activities in house.

RESEARCH POLICY AND PROMOTION

WHO objective(s)

To stimulate research for, with, and by developing countries by identifying emerging trends in scientific knowledge with the potential to improve health; inciting the world research community to tackle priority health problems; and launching initiatives to strengthen research capability in developing countries so that research may be recognized as the foundation of health policy.

Summary of achievements

- WHO's ethical review committee on research involving human subjects streamlined and systematized the process for ensuring ethical compliance in WHO-sponsored research.
- The process for administering the global network of WHO collaborating centres was improved, standardized and made more efficient by means of a comprehensive database.

Illustration of achievements at country, regional or global levels

- A major report on genomics and world health, produced by the WHO Advisory Committee on Health Research (ACHR), was released to highlight a major emerging trend in scientific knowledge with the potential to improve health.[1] The report was well received by the health and scientific community, gaining excellent visibility and coverage in the international media. Its principal recommendations were submitted to the Executive Board at its 111th session in January 2003,[2] and discussed by the Board at its 112th session in May 2003,[3] thus helping to raise awareness of the implications of genomics for public health.
- An important initiative on health research systems analysis was launched in 2002. The initiative supported the work of regional offices and countries in analysing national health research systems in order to facilitate the application of research data to health policy formulation.

Achievement of expected results

WHO research policy updated to include emerging trends, contemporary scientific advances relevant to health, gaps in knowledge, and ethical aspects of research in order to assure rational decision-making on research priorities

Indicator	Baseline	Target	Achievement
Degree of reflection in WHO's research-policy positions of current trends and advances in knowledge and of good ethical standards	There was no clear WHO position on the potential of genomics for health; ethical review within WHO sporadic and not systematized	A major report on genomics and world health; good ethical standards practised in house to review WHO-sponsored research	The report on genomics and world health published; higher global visibility gained for implications of genomics for public health, better awareness achieved of ethical, legal and social implications. Efficient ethical review of WHO research in place
Level of prominence and presence of WHO research policy in the global health-research agenda			

[1] *Genomics and world health: report of the Advisory Committee on Health Research*. Geneva, World Health Organization, 2002.

[2] Document EB111/12.

[3] Document EB112/2003/REC/1, summary record of the first meeting, section 4.

Mechanisms in operation for setting up networks and partnerships to improve international cooperation for health research, including practical and sustainable collaborative mechanisms between the global and regional ACHR

Indicator	Baseline	Target	Achievement
Number of regional ACHR with explicit operational and procedural links to the global ACHR	3 regional ACHR with close links to global ACHR	6 regional ACHR with close links to global ACHR; close coordination in setting meeting dates	6 regional ACHR with close links to global ACHR. Closer coordination and dialogue between regional and global research issues and priorities achieved

Framework in operation for providing policy and technical support in order to strengthen health research capability in developing countries

Indicator	Baseline	Target	Achievement
Number of regional offices, country offices and WHO collaborating centres with real-time web access to the major global databases of scientific and policy information relevant to health research and other databases related to WHO research activities, expert advisory panels and WHO collaborating centres	Few country offices and WHO collaborating centres with good access to databases No information available for regional offices	Internet and Intranet access to databases of collaborating centres and expert advisory panels; access to scientific databases and literature	Approximately 10% to 20% achieved, owing to resource and access limitations. Databases of WHO collaborating centres and expert panels now accessible from both Internet and Intranet at regional and country offices

Support and advice provided within WHO on research-related activities

Indicator	Baseline	Target	Achievement
Evidence of the importance given to health research issues in WHO documentation and press releases	Limited mention of health research issues in WHO documentation and reports	Health research integrated into all areas of WHO's work, not just those traditionally involved in research	Partially achieved and several reports and position statements highlighted role of research (e.g. in mental health, violence and injuries)

WHO collaborating centres increasingly capable of involvement in high-priority research

Indicator	Baseline	Target	Achievement
Increased involvement of WHO collaborating centres in high-priority areas of research within national and regional inter-centre networks	Limited number of networks in priority areas, centres often working in isolation	Strong networks in key priority areas	Networks set up (e.g. in environmental health and classification of diseases) but creation and coordination of additional networks limited by lack of technical staff
Financial support provided to WHO collaborating centres for research-related activities in priority areas	No financial support for research conducted by WHO collaborating centres	Financial support for WHO collaborating centres for research activities	Financial support not provided to collaborating centres' research activities owing to lack of resources

Critical impediments

Internal: the necessary skill set was not always in place and the level of support for research varied between regions.

External: supportive environments for health research were lacking, as were capacities for health systems research in countries. Poor coordination among key agencies and inadequate financial resources were also reported.

Relevance and adequacy

Achievement of the expected results continued to be relevant to the overall WHO objective of promoting research in health policy-making and the relevance was further broadened by the inclusion of activities related to the ethics of health research. However, achievements were inadequate owing to resource and technical limitations.

Budget adopted by the Health Assembly versus expenditure

Total expenditure including regular and extrabudgetary sources for 2002-2003 was US$ 12 551 000, representing 112.9% of the total programme budget (US$ 11 114 000).

Total programme budget versus expenditure and expenditure by office (US$ thousand)

Area of work – programme budget	**11 114**
Area of work – expenditure	**12 551**

Expenditure by office:

Headquarters	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
5 894	306	654	1 448	2 507	1 446	296

Lessons learnt

- The programme development process should from the outset involve close coordination to identify common areas of concern between headquarters and regional offices, as well as areas specific to the regions.
- Greater attention should be paid to capacity building in health systems research at national level, together with networking among different experts involved in health research to enhance coordination of activities.
- There is a need to make better use of WHO collaborating centres and the ACHR system to provide support to countries in developing health research policies and strategic plans, national health research coordination mechanisms, and bioethics and scientific review committees.
- Developing too many products dilutes impact at country level and should be avoided.
- Countries continue to look to WHO for leadership and guidance on newly emerging, and potentially controversial issues such as genomics. WHO is perceived as an independent and objective body that is well placed to provide advice to countries. The international credibility of the Organization should therefore form the basis for further work.

ORGANIZATION OF HEALTH SERVICES

WHO objective(s)

To work with ministries of health in order to strengthen the capacity of countries to deliver high-quality health services affordably, efficiently and equitably to all their populations, especially those most vulnerable, by developing and enhancing systems for planning and delivery of health services, and for gathering evidence and designing tools that support informed and participatory framing and implementation of policy.

Summary of achievements

- New partnerships were forged with many institutions, including the African Union, ILO, and the International Organization for Migration.
- Increased collaboration was achieved with multilateral institutions, such as the World Bank, the Council of Europe, the European Union, the Inter-American Development Bank and the Asian Development Bank.
- Guidance documents in many key areas were developed and shared with countries. Subjects covered included stewardship, the role of hospitals, accreditation, contracting and district management.
- Each region completed a review of primary health care activities during the biennium; headquarters also prepared a summary document and organized a technical meeting on the same subject.

Illustration of achievements at country, regional or global levels

- The health system performance framework was adapted at country level in the WHO European Region, in partnership with several stakeholders.
- In south-eastern Europe, WHO was a partner in improving emergency medical services in countries.
- The Regional Office for the Americas made significant efforts to implement the essential public health functions with ministries of health and strengthen their stewardship capacity.
- The Regional Offices for South-East Asia and the Eastern Mediterranean supported quality improvement in health services through continuing professional development; an accreditation process was also introduced in several countries. The Regional Offices for Africa and the Western Pacific supported the development of national policies for human resources for health, and the observatory of human resources in health and the "virtual campus" in public health were developed by the Regional Office for the Americas.
- As reported by the Regional Office for the Western Pacific and supported across WHO, better coordination and collaboration among all partners and commitment of national counterparts facilitated implementation, although room for further improvement remained.

Achievement of expected results

Evidence and best practices validated and promoted in order to define policy options for countries on provision of health services, development of human resources, and fulfilment of stewardship

Indicator	Baseline	Target	Achievement
Use of WHO policy options	Very few developing countries have policies for human resources for health	10 countries using WHO policy options approach	6 countries conducted in-depth reviews of human resources for health, using WHO tools. At least 4 others elaborated plans on human resources for health. 6 countries given support in developing hospital service policies

Alternative models of health service delivery at all levels of the health system analysed and promoted

Indicator	Baseline	Target	Achievement
Access of countries to alternative delivery models	All countries have delivery models and many are being reviewed	7 countries testing implication of policy intervention and delivery models	While number of countries not known, a global review of primary health care indicated that countries such as Benin, Brazil, Canada, Malaysia and New Zealand adapting primary health care to present environment. Others introducing innovative ways to reach poor and disadvantaged populations (e.g. Bangladesh).

Frameworks validated for use by countries to gather and analyse health systems changes and reform and their impact on service delivery, and to strengthen their capacity for policy framing and implementation

Indicator	Baseline	Target	Achievement
Number of case studies under way in targeted countries, after testing of assessment frameworks	All developing countries have need	Not established	Number of studies not tracked. However, a framework for rapid health system assessment and planning developed, as well as guidance for a rapid assessment of health system organization and performance in countries A framework for subnational performance assessment applied to 4 countries A review of approaches for management performance assessment conducted. A strategy for management development tested and applied to 2 countries

Database of best practices and operational networks compiled and updated in order to support implementation of health system functions in countries and to strengthen partnerships

Indicator	Baseline	Target	Achievement
Completeness in updating database of best practices	Not established	Not established	Although this activity initiated, is at different stages across regions. Database therefore not compiled
Proportion of targeted countries in each region involved in networks using database			

Strategies, methods, guidelines and tools devised to enable countries to improve the delivery and quality of health services to individuals and populations; benchmarks defined in collaboration with Member States and partners

Indicator	Baseline	Target	Achievement
Proportion of targeted countries having introduced WHO strategies, methods, guidelines and tools for improving the delivery and the quality of services	Not established	At least 10 countries to be approached to use tools and monitor impact	Tools only developed in last part of biennium Development of method to use routine hospital data to assess quality Common understanding of concepts and terms, and a taxonomy for patient safety developed

Methods, guidelines and tools devised for planning, educating, managing and improving the performance of the health workforce, harmonizing participation of the private sector in achievement of national goals, and assessing and implementing models of health service provision

Indicator	Baseline	Target	Achievement
Use in targeted countries of WHO methods, guidelines and tools developed for improving the performance of health workforce and the provision of service	Not established	By end of 2003, the essential healthcare technology package (EHTP) fully tested in 6 countries and at least 2 countries in Africa able to support its application	6 countries. EHTP tested in China, Kyrgyzstan, Mozambique, Namibia, South Africa and Ukraine. Kyrgyzstan, Mozambique, Namibia and South Africa have included EHTP in their strategic planning processes

Technical and policy advice based on evidence and best practices provided to countries in order to improve provision of health services and investment in, and use of, human, material, and capital resources

Indicator	Baseline	Target	Achievement
Efficient operation of WHO system for responding to requests from countries	Not established	Development of tracking system for requests, subsequent reports, follow-up and a simple mechanism for judging client satisfaction	Tracking system for requests and reports developed
Mechanisms for evaluating use of technical and policy advice in place			Mechanism for judging client satisfaction not yet developed

Critical impediments

Voluntary contributions did not arrive when expected, delaying implementation and greater emphasis was placed on the development of quantitative evidence, rather than on qualitative or country-based work.

Relevance and adequacy

Achievement of the expected results continued to be relevant. The capacity of health systems to deliver appropriate services remained a significant challenge. This was especially critical for HIV/AIDS prevention and treatment and other challenges to health systems. *The world health report 2003* clearly identified the need for this area of work;[1] however, it needed to be more closely linked to the Department of essential medicines and other relevant areas of work.

Budget adopted by the Health Assembly versus expenditure

Total programme budget versus expenditure and expenditure by office (US$ thousand)

Area of work – programme budget	57 923
Area of work – expenditure	55 725

[1] *The world health report 2003. Shaping the future.* Geneva, World Health Organization, 2003.

Expenditure by office:

Headquarters	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
20 166	10 563	4 516	2 791	4 905	7 217	5 567

Lessons learnt

- More attention should be paid to the development of baselines and achievable targets. Although establishing baselines is difficult in health systems, an agreed solution has to be arrived at with the regions.
- Workplans for the 2004-2005 biennium should endeavour to set more precise targets and indicators.
- Greater collaboration among partners within and outside WHO are required for this area of work; this should be the focus of major efforts in 2004-2005.

GOVERNING BODIES

WHO objective(s)

To provide support to the regional and global governing bodies in the form of the efficient preparation and conduct of their sessions, including dissemination of easily accessible, readable and high-quality documentation for policy-making.

Summary of achievements

- During the biennium, each of the regional committees met twice, generally with one or more standing committees or subcommittees carrying out the preparatory work.
- Meetings of the governing bodies were held as planned, as per the requirements outlined in the WHO objectives of accessibility, readability and recognized quality.
- Major achievements included the adoption of the WHO Framework Convention on Tobacco Control and the finalization of the review of the working methods of the Executive Board. Meetings were held in the appropriate official languages and documentation was provided in the languages prescribed by the rules of procedure of each governing body, or the parent governing body in the case of subsidiary committees.

Illustration of achievements at country, regional or global levels

- At the global level, in addition to the Health Assembly and the two sessions of the Executive Board organized each year, the following subsidiary meetings were held: the final three sessions of the Intergovernmental Negotiating Body on the WHO framework convention on tobacco control, six meetings of an ad hoc open-ended intergovernmental working group to review the working methods of the Executive Board, two meetings of the Programme Development Committee, four meetings of the Administration, Budget and Finance Committee and four meetings of the Audit Committee.
- Regional committees focused on global as well as regional issues. For example, preparatory work on tobacco control carried out at regional level proved essential in framing the final framework convention on tobacco control.

Achievement of expected results

Adoption of resolutions that are focused on policy and strategic issues and that provide clear orientations to Member States and WHO's Secretariat on their implementation and monitoring

Indicator	Baseline	Target	Achievement
Number of resolutions passed that are policy focused and implementable at global and local levels	Review of resolutions under way. Baseline not set	Not established	Strong emphasis on realistic reporting frameworks: 13 of 23 Health Assembly resolutions with technical reporting frameworks either "as appropriate" or of two or more years

Communication between Member States/Board members and WHO's Secretariat improved

Indicator	Baseline	Target	Achievement
Increase in the number of communication channels open to Member States and governing bodies, at global, regional and country levels, concerning the work of WHO's Secretariat	Not established	Not established	Use of electronic means to circulate documents systematized at all levels, resulting in increase in number of visits to global Governance web site (from 12 000 in July 2003 to 17 000 in October 2003); figures for visits to web sites of regional committees also increased

Documents and information products of the Organization available in the different languages of the Organization

Indicator	Baseline	Target	Achievement
Proportion of essential documents and information products that are translated into the languages of the Organization	100%	100%	All documentation for the Health Assembly, Executive Board and regional committees translated into appropriate languages; however, several instances where lengthy background documents could not be made available in all six languages for the Executive Board or Health Assembly. Regions did not report experience of this problem
Timeliness of availability of governing body documents to Member States	Regions: 100% produced within time frame of the rules of procedure Headquarters: 80% produced within the time frame of the rules of procedure	Regions: 100% Headquarters: 100%	Regions: 95% Headquarters: 85% Regions reported good compliance. For Executive Board and Health Assembly, problems continued with late receipt of documents, including those late for reasons concerning reporting period (e.g. annual report on human resources and Member States in arrears). In general, late submissions resulted from non-compliance with deadlines

Critical impediments

Insufficient financial resources represented the major impediment; difficulties were experienced not only in meeting the increasing cost of planned activities, but also in absorbing the unplanned, incremental increase in the number of meetings of subsidiary bodies organized over the biennium. Minor impediments, such as late nomination of participants and logistical problems, are a feature of each meeting and are dealt with as they arise.

Relevance and adequacy

Coordination on policy issues between regional and global levels was good, acting as a resource for Member States to ensure that attention was paid to regional issues. Work remained to be done here, however, as the method of adopting agendas for the Executive Board and Health Assembly did not allow for sufficient input from the regions, as opposed to Member States.

Budget adopted by the Health Assembly versus expenditure

Regions report reasonable consistency between budgeted and actual expenditure. Governing bodies are subject to the effect of currency exchange for purchase of services. At headquarters level, a series of unplanned consultation processes and an ad hoc open-ended intergovernmental working group to review the working methods of the Executive Board were above and beyond the programme budget. Additional resources were provided from the Director-General's Office.

Total programme budget versus expenditure and expenditure by office (US$ thousand)

Area of work – programme budget	**22 439**
Area of work – expenditure	**23 505**

Expenditure by office:

Headquarters	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
19 445	2 125	62	289	706	393	485

Lessons learnt

- Budget forecasting is probably the most significant area where improvements can be made; however this activity can only be performed on the basis of what is known at the time of preparation.
- There is a need to further improve the coordination of global and regional agenda-setting.
- Realistic document planning and improved compliance with those plans are required at all levels. Greater discipline in respecting limits on the length and layout of documentation is also needed.

RESOURCE MOBILIZATION, AND EXTERNAL COOPERATION AND PARTNERSHIPS

WHO objective(s)

To build up WHO's collaboration with organizations of the United Nations system, intergovernmental bodies and nongovernmental organizations; to improve internal coordination between the three levels of the Organization as "one WHO"; to provide high standards of information to various media, and better access to it; to mobilize resources from a broader donor base; to negotiate and sustain partnerships for world health, and to secure the Organization's resource base.

Summary of achievements

- Total voluntary contributions for programme budget activities (US$ 1 146 000 000) were maintained at the high level of the previous biennium.
- Significant progress was made in securing donor government support for the integrated programme budget, within multiyear commitments made by areas of work; the concept of joint reporting to donors was also developed further.
- New memoranda of understanding were developed with Australia, France, Netherlands, Norway, Spain, and others, providing a basis for better cooperation.
- Modalities of cooperation were streamlined with the European Commission, the United States Agency for International Development and the OPEC Fund for International Development, as well as with several foundations and local authorities, greatly facilitating increased funding.
- Targeted approaches to foundations, particularly in the context of longer-term partnerships, continued to provide an effective basis for sustained support. The guidelines for interacting with the private sector proved effective in setting the framework for such collaboration.

Illustration of achievements at country, regional or global levels

- Health issues received unprecedented attention from the international community and were regularly included in national and international planning exercises, such as the country cooperation strategy, the Common Country Assessment, the United Nations Development Assistance Framework and the poverty reduction strategy papers.
- WHO succeeded in defining the country focus initiative; wide internal and external consensus on the initiative, and commitment to it, were also achieved, marking the first step in the process of transforming WHO into a country-centred organization. The country focus initiative enjoyed extensive support in regional offices and among Member States, and financial support was received from main donors.
- Following an intense advocacy effort, WHO programmes became more country-focused; WHO Representatives also took the lead in priority-setting for the country focus and decentralization processes, in which the country cooperation strategy is seen as the basis for integrated country support.
- By the end of 2003, 47 countries had developed a country cooperation strategy, while 38 others were in the process of completing their strategy. In the WHO South-East Asia Region, 11 country cooperation strategies were under review.

Achievement of expected results

A collaborative network in operation with organizations of the United Nations system, intergovernmental bodies and nongovernmental organizations, supported by regular reviews, together with an active liaison network with multilateral institutions

Indicator	Baseline	Target	Achievement
WHO goals and priority health concerns reflected in final declarations and plans of actions of global, regional and national conferences, and in development agendas	Global health concerns insufficiently represented in development forums, conferences and international meetings	Systematic reference and inclusion of WHO priorities reflected in declarations and plans of action of global and international scope	Health systematically included in international development agendas. Coordination platforms being created with agencies and funds within the United Nations and in a multilateral context, providing a network of sustained support to health issues. Regular overhaul of cooperation in global and public health issues organized with the World Bank, other United Nations bodies, development partners and wider civil society

More effective mechanisms in place for coordination and exchange of information between different levels of the Organization; functioning of WHO country offices improved through training and guidelines for WHO Representatives; database compiled on the operations and staffing of country offices; and a telecommunication network installed for exchange of information

Indicator	Baseline	Target	Achievement
Improved capability of all levels of the Organization to deal with issues as "one WHO", reflecting a common vision on health development	No report to governing bodies	Produce and support Executive Board report	Report submitted to Executive Board on country focus initiative and fully supported by Member States.[1] The report based on intensive consultations with a broad range of interested parties, including the six WHO regional offices, as well as Member States, and health development partners; this led to consensus and a common vision of how to improve support for national health development
	Early institutionalization of the country cooperation strategy	Country cooperation strategy institutionalized	Acceptance of the country cooperation strategy as basis for country support and improving coordination and exchange of information; need to link it to overall managerial process recognized (clear outcome of the third global meeting of WHO Representatives and Country Liaison Officers)
	Limited reflection of country focus in the programme budget	Country focus on strengthening WHO country presence improved across areas of work	The third global meeting of WHO Representatives and Country Liaison Officers, resulted in consensus on priority-setting for strengthening WHO country presence, country focus and the decentralization agenda

[1] See document EB111/2003/REC/2, summary record of the seventh meeting.

Indicator	Baseline	Target	Achievement
	Limited involvement of WHO Representatives and Country Liaison Officers in global policy- and strategy-making	WHO Representatives and Country Liaison Officers considered part of senior management and involved in policy planning	

A comprehensive approach, including training, defined for provision of information on world health targeted to appropriate audiences; image of WHO enhanced and support increased for its priority objectives; coordinated network of information offices across the Organization set up, enabling prompt, accurate and proactive dealings with the media and the public, relevant to regions and countries

Indicator	Baseline	Target	Achievement
Improved capacity of WHO to convey information about its mission and work. Improved public knowledge of WHO, in particular its priority areas of work	Gaps in communications capacity in clusters at headquarters	Each cluster to have at least 1 communications focal point	Each cluster, except General Management, had at least 1 communications professional at the end of 2003
	Insufficient coordination mechanisms with WHO regions	Improved coordination mechanisms with WHO regions	Regional coordination mechanisms improved through sharing of media coordination group minutes and other outreach, though still not optimal
	In 2000, WHO referred to 2648 times in major world publications	Double number of WHO references in major world publications in 2003	WHO referred to 13 752 times in major world media in 2003, representing 5 times the value in 2000. Outbreak of severe acute respiratory syndrome partly responsible, but proactive work including on poliomyelitis eradication, tuberculosis, and "3 by 5" initiative, also played significant role
	In 2000, WHO web site inadequate	New web site by mid-2002, recording significant web hits	New WHO web site launched in July 2002. In 2003, the WHO homepage viewed over 33 million times in English, French and Spanish

Dynamic, coordinated and decentralized fundraising under way with current and potential donor countries, public and private sector partners, including regional development banks, nongovernmental organizations, and foundations

Indicator	Baseline	Target	Achievement
Improved responsiveness of funding partners to WHO's priorities and initiatives	Development and maintenance of contacts and partnerships with donor community to secure funding of programme budget as approved by the Health Assembly	Alignment of voluntary contributions with programme budget in terms of levels, programme priorities and time frame	Two thirds of voluntary contributions came from governments, enhancing corporate nature of support and sustainability Efforts to strengthen support from intergovernmental organizations and foundations focused on improved cooperation with technical programmes

Indicator	Baseline	Target	Achievement
	Organization of annual Meeting of Interested Parties	Review corporate programme, action and impact of WHO with public and private sector partners	Meetings of Interested Parties successfully held in 2002 and 2003 with thematic agenda, greater range of participants, and active involvement of regional and country offices
Ability to achieve target increase in extrabudgetary resources	Development and implementation of strategic and systematic approaches to resource mobilization, on corporate and decentralized basis	Broaden donor base and increase support through targeting of donors according to their mandates and capacities	Voluntary cash contributions received from range of public, private and philanthropic donors, at both multilateral and bilateral levels, representing an improvement on 2000-2001 biennium

Critical impediments

Internal: WHO needed to change organizational culture and ways of working in order to become more effective through greater decentralization.

External: the evolving international environment led to a change in expectations concerning WHO, especially at country level. WHO needed to adapt rapidly to meet these expectations; however, lack of capacity and resources remained constraining factors. Efforts needed to be continued both to increase country involvement in the country cooperation strategy and to strengthen the role of country offices in order to establish the strategy as the main guide for technical cooperation; the involvement of the regional offices and headquarters was particularly important in this area. The strengthening of WHO's country presence also revealed significant gaps in resources; these needed to receive attention over the next biennia.

Relevance and adequacy

Achievement of the expected results for the period under consideration was deemed adequate: the relevance of health was more visible in discussions about development; poverty reduction programmes were better aligned with broader development issues, and health was increasingly included as a cross-cutting subject; participation in development discussions was adequate and increased attention was being paid to health issues as a result. Efforts undertaken in the area of creating networks in health could thus be considered satisfactory. In addition, WHO was respected within United Nations coordination platforms and the Organization continued to participate actively in various working groups for reform of the United Nations.

Budget adopted by the Health Assembly versus expenditure

The over-expenditure was due to three factors: first, unspent allocations from a number of donors are returned to the budget of the Department of resource mobilization, and external cooperation and partnerships at the end of each biennium, pending reallocation. The Department's budget therefore becomes a "parking" account for other clusters. Related expenditures are then transferred to other areas of work, and are thus not actually the Department's expenditures. Similarly, expertise funds aimed at financing short-term experts in clusters and regions are administered by the Department. Second, it has been customary in the WHO Regional Office for the Western Pacific to credit the totality of the Region's share of Japan's annual contributions to this area of work and to make programme expenditure directly from this budget. The Department budget is again a "parking" account for the sums involved. Finally, an amount of US$ 5 300 000 was charged by the WHO Regional Office for Africa to this area of work, although it covered expenditures made at country level.

Total programme budget versus expenditure and expenditure by office (US$ thousand)

Area of work – programme budget	**35 307**
Area of work – expenditure	**52 316**

Expenditure by office:

Headquarters	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
19 816	8 415	1 716	1 258	2 274	4 002	14 835

Lessons learnt

- Transparency and inclusiveness in addressing health issues lead to positive outcomes.
- Capacity building in favour of national counterparts remains the cornerstone of WHO's strength.
- Combining the Organization's goals with national development objectives encourages excellent relations while maximizing the output of technical cooperation efforts.
- Change can be brought about through Organization-wide commitment, using a participative process with strong endorsement and support on the part of senior management and the governing bodies.
- Strong global guidance in 2000-2001 gave way to increased regional responsibilities in 2002-2003, enabling further institutionalization of the country cooperation strategy.
- The right balance between flexibility and corporate standards needs to be found if the country cooperation strategy is to become a corporate WHO instrument, helping the Organization to provide better support to countries in all their diversity.
- WHO country offices and some regional offices were instrumental in setting priorities for change.
- A stronger resource base should be built, with effective country offices working in close collaboration with national authorities and other development partners in health.
- More information is required on the implications of the country cooperation strategy for defining WHO's core country presence and the core functions and roles that this implies. Responsibilities across different levels of the Organization need to be more clearly defined.
- Capacity building in support of WHO Representatives and country teams is required to facilitate their adaptation to the new functions expected of them within the country cooperation strategy.
- In the future, achievements related to media coverage should be measured in terms of quality of coverage, and coverage across the broad spectrum of world media (including in different languages) rather than in terms of the number of media references recorded.
- Advocacy in favour of the correlation between health status and economic well-being is crucial for ensuring the inclusion of global and public health issues on international development agendas.
- Collaboration and sharing of responsibilities and successes create a solid basis for participation in discussions on global issues. Transaction costs are reduced when cooperation is synchronized among development partners.
- The integrated presentation and management of WHO resources facilitated more coherent and corporate resource mobilization strategies and approaches.
- More incentives are required to encourage the organization across areas of work of initiatives towards integrated country support and to help country offices to become resource management centres.
- WHO's increasing reliance on extrabudgetary resources for its normative and operational work makes resource mobilization an absolute priority.

BUDGET AND MANAGEMENT REFORM

WHO objective(s)

To develop Organization-wide and effective mechanisms for results-based management and cost-effective administration, anchored in WHO's corporate strategy.

Summary of achievements

- Greater focus was concentrated on results-based planning and performance assessment in this area.
- The design of an integrated results-based managerial framework was completed, including planning, budgeting, monitoring and evaluation.
- Remodelling of the activity management system in support of the results-based framework was completed.
- Orientation and training activities on results-based management and the logical approach to managing programmes were pursued intensively, particularly in the regions.
- Better workplan compliance was recorded both at headquarters and in the regions.
- A move away from activity-based planning towards a more strategic orientation was successfully undertaken, albeit with variations among offices.
- The programme budget and other statutory documents were submitted by all regions in a compatible format. This reflected the new planning and budget appropriation structure, with Organization-wide expected results formulated in relation to common areas of work.
- Progress in evaluation was recorded and thematic evaluations were performed in regions, including follow-up on recommendations; further work was carried out on the development of a framework for country evaluation and an Organization-wide evaluation of fellowships was initiated.

Illustration of achievements at country, regional or global levels

- The move to results-based budgeting was reported to have improved transparency and accountability in the WHO South-East Asia and Eastern Mediterranean Regions.
- In the Western Pacific Region, the focus on improved managerial processes shifted to the achievement of expected results, providing a framework in which the contributions of countries, areas and regions towards the achievement of Organization-wide expected results were more clearly articulated.
- In the European Region, resource allocation mechanisms and focus in support of Member States were reported to have improved.
- In some regions and at headquarters, technical units and programme managers were considered more accountable and performance monitoring and reporting were strengthened.

Achievement of expected results

A fully integrated and results-based planning, budgeting, monitoring and evaluation system in operation across the Organization

Indicator	Baseline	Target	Achievement
Consistency between global strategic planning (programme budget) and subsequent operational planning at all levels (workplans)	Not established	Not established	Review of workplans at headquarters revealed improved consistency between the two planning levels in terms of linkage between products and expected results. In regions, products also linked to Organization-wide expected results despite some difficulties, especially in the Region of the Americas and the Western Pacific Region

Indicator	Baseline	Target	Achievement
Consistency of monitoring, reporting and evaluation procedures at all levels	Not established	Not established	In the regions, continuous monitoring maintained (WHO South-East Asia Region), periodic progress reports and mid-term assessments utilized in monitoring (Region of the Americas), and mid-term reviews consistent with global procedure used to improve planning and programme budget implementation (Western Pacific Region) Completion and use of Organization-wide guidance materials on planning, monitoring and evaluation ensured better common understanding and improved reporting, while facilitating updating of regional guidelines in conformity with results-based management principles

Consistent administrative rules and practices in operation in support of efforts to achieve greater accountability and better performance in the Organization

Indicator	Baseline	Target	Achievement
Effective operation of new administrative systems in place at all organizational levels	Not established	Not established	Electronic WHO Manual updated and improved, incorporating new policies and procedures enacted within WHO reform process – now the only authenticated version Access to and updating of WHO Manual greatly improved through staff training, the file transfer protocol server and better distribution

Cost-effectiveness in administrative functions improved on the basis of new policies and of recommendations of selected management reviews

Indicator	Baseline	Target	Achievement
Improved service and/or efficiency generated from the implementation of reform measures	Not established	Not established	Major reviews conducted of the following: WHO's policies and provisions for delegation of authority, organization and functioning of management support units, and Organization's administrative service arrangements (including those with UNAIDS and the Global Fund to Fight AIDS, Tuberculosis and Malaria). As a result, executive management able to reorganize services and weigh impact of delegation of authority arrangements on accountability and on efficiency and quality of technical programmes

			Recommendations of the Joint Inspection Unit (JIU) review of management and administration in WHO implemented promptly,[1] together with new provisions of follow-up agreement with JIU

Mechanisms and systems in operation for monitoring and reporting on efficiency savings at all organizational levels

Indicator	Baseline	Target	Achievement
Timeliness and completeness of reporting on efficiency measures, across all WHO offices	Not established	Not established	A revised efficiency monitoring system allowed for elimination of delays, discrepancies and omissions encountered during previous biennium Revised data set resulted in more timely and less burdensome reporting of efficiency data and addressed comparability issues

Critical impediments

Internal: differing approaches to results-based management, including the use of non-standardized planning elements, systems and processes in some regions, prevented easy measurement and aggregation of results. Some office-based accounting procedures, for example, were not compliant with results-based budgeting. Furthermore, at the end of the period under review, integrated planning covering all levels was still not in place and certain offices did not articulate plans in relation to Organization-wide expected results. Application of indicators also proved problematic, especially as baseline data and targets had often not been set at the outset of the biennium. Poor compliance in provision of data for the activity management system (or equivalent regional system) prevented the core data set from being fed into the global database, and the web tool for the activity management system required further refinement since it did not fully support the business model.

External: Organization-wide restructuring, which had been continuing since July 2003, together with other organizational and functional changes had an effect on workflow. In the WHO South-East Asia Region it was reported that uncertainty of extrabudgetary allocations to countries and programmes had prevented the full integration of programme budgeting. In the African Region, insufficient resources (as well as problems with information technology infrastructure in some countries) delayed the planned implementation of the activity management system in some locations. Lack of resources and late funding also prevented the Eastern Mediterranean Region from implementing activities on time, which caused tasks to be rescheduled during the 2004-2005 biennium.

Relevance and adequacy

Achievement of the expected results continued to be relevant (although contributions to their achievement were limited in some regions, owing to differing planning processes). Furthermore, it was noted that some expected results were too general and abstract to provide sufficient guidance for the development of office-specific results.

Budget adopted by the Health Assembly versus expenditure

The programme budget for the area of work was established at US$ 7 932 000. The difference between the programme budget and the US$ 9 348 000 recorded as expenditure was due to the implementation of the programmatic evaluation plan, particularly in the regions, together with the remodelling plan for the activity management system, which was prepared after the adoption of the programme budget.

[1] Document JIU/REP/2001/5.

Total programme budget versus expenditure and expenditure by office (US$ thousand)

Area of work – programme budget	**7 932**
Area of work – expenditure	**9 348**

Expenditure by office:

Headquarters	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
4 589	1 364	24	867	1 429	518	557

Lessons learnt

- Implementation of the WHO results-based management framework continues to vary in terms of application and compliance. In some offices, the requisite change in business culture has not yet been fully accomplished.
- It is apparent that the active involvement of managers is essential for institutionalizing results-based management and achieving the integration of regional and Organization-wide planning processes.
- Training is crucial for building capacity and it has been noted in all the offices that investments in training need to be sustained and intensified. This is especially true at the country level, if gains in the area of results-based management are to be consolidated.
- The shift to results-based budgeting is an incremental process and other administrative systems such as finance and human resources should be brought into alignment.
- Evaluations should be presented in a user-friendly manner to maximize the use of recommendations; they should also be carried out with the broad involvement of stakeholders.

HUMAN RESOURCES DEVELOPMENT

WHO objective(s)

On the basis of the corporate strategies to maximize staff motivation and productivity through efficient, effective and fair policies, processes and advice for human resources.

Summary of achievements

- The human resources reform process – involving extensive discussions with staff, management and governing bodies – resulted in a number of policies and procedures aimed at maximizing staff motivation and productivity.
- The capacity of the Organization to respond to emerging trends in staff and management requirements has been enhanced, particularly in the areas of staff development, administration of justice, together with administrative procedures in line with organizational needs, based on best practice prevailing in other public and international organizations.
- Full implementation of the e-recruitment system was achieved worldwide.
- The granting of service appointments was successfully introduced.
- A competency-model framework was developed for job classification, recruitment, performance evaluation, development training needs assessment and development of learning programmes.

Illustration of achievements at country, regional or global levels

- Compliance with the performance management and development system in the WHO Regional Office for the Eastern Mediterranean was approximately 80%.
- The Regional Office for Europe achieved 47% female representation in the professional and higher categories. A comprehensive induction programme was developed for new staff and 236 training and briefing events were organized.
- Staff services were made more responsive in the Regional Office for Africa, through the recruitment of four human resources officers and 10 new human resources assistants, together with the installation of a new personnel management system.
- Human resources reforms introduced by the Regional Office for South-East Asia improved terms of employment and raised staff morale.
- Administrative procedures and practices were streamlined in the Regional Office for the Western Pacific, particularly the recruitment process for short-term staff and consultants; this facilitated rapid recruitment of staff during the outbreaks of severe acute respiratory syndrome and avian influenza.

Achievement of expected results

Project for reform of human resources completed; further requirements identified through an evaluation of reform efforts

Indicator	Baseline	Target	Achievement
Timely completion of all agreed reform measures	Recommendations of the task force on human resources reform not yet approved	Approval and implementation of all recommendations on human resources reform	Human resources reform and review of roles, responsibilities and structures in human resources management in place throughout Organization Establishment of short-term and term-limited employment options with related benefits (service allowance, staff health insurance and maternity leave) Establishment of procedures for selection, recruitment and extension of temporary staff

Indicator	Baseline	Target	Achievement
			Establishment of service appointments and procedures to grant such appointments from 1 July 2002 Establishment of a reassignment process and enhanced termination indemnity for staff serving on posts of indefinite duration or staff holding career service or service appointments Review of "long-term short-term" staff and possible transition to fixed-term status. Solutions identified for more than 110 such staff until December 2003 Work on developing staff ethics framework continued in 2002-2003 Formal terms of reference established in 2002 for an Organization-wide mechanism for staff/management consultations – the Global Staff/Management Council Work on rewards and recognition in 2002-2003 resulted in a number of options, pending introduction of reforms being undertaken at common system level
Definition of future reform requirements	Review of achievements and identification of issues requiring additional emphasis	Development of a human resources strategy for 2004-2005	Strategy document on the way forward for human resources management for period 2004-2005 developed and endorsed

Information for human resources management improved in support of decision-making on human resources at all levels

Indicator	Baseline	Target	Achievement
New human resources information system and procedures in place, providing more information and better access to human resources officers and line managers	Effective re-engineering and streamlining of human resources business processes	Accessible, integrated technology systems that permit effective and efficient management of human resources processes	The e-recruitment system successfully implemented in headquarters and regional offices The e-post description system created, incorporating online workflow and automated approval process A functional, online mock-up of the human resources e-guide designed

Organization-wide strategy for leadership and staff development implemented, monitored, and systematically evaluated

Indicator	Baseline	Target	Achievement
Measurable improvement in levels of job performance and satisfaction of personnel participating in staff development	Baseline data was collected by staff survey in May 2003; global core management and leadership competencies available for testing; general approach to global management and leadership development learning programme designed and proposals sought for 2004 delivery	Overall increase against indicators in 4 of 6 principles and their indicators in United Nations organizational learning framework for the next biennium	Global WHO competency model being progressively implemented; various tools being developed in conjunction with regions and headquarters
Better staff development opportunities contributing to recruitment and retention of highly qualified staff	New strategic approach to global staff development agreed in 2003; 2 benchmarks set: 2% of staff costs and 5% of staff time to be implemented in 2004	A series of new global development courses delivered and evaluated in 2003; agreed global approach to supplying staff development programmes, using a global training management system in 2004	Global learning programmes developed for communication, negotiation skills, writing, security, induction and administration

A rotation and mobility system established covering internationally recruited staff

Indicator	Baseline	Target	Achievement
Systematic rotation of internationally recruited staff throughout the Organization	No scheme of systematic rotation in place	To achieve greater movement of staff among the various WHO programmes and duty stations	Ad hoc rotation achieved while Organization-wide scheme being finalized

Human resources services of a high quality provided to meet current and future requirements of the Organization's programmes (e.g. recruitment and contract administration consistent with efficient and effective programme delivery, agreed strategies for meeting targets for gender equity and geographical representation at global and regional levels)

Indicator	Baseline	Target	Achievement
Drafting and application of guidelines for human resources planning	No comprehensive human resources planning undertaken on an Organization-wide basis	To introduce a system of planning enabling WHO to forecast human resource needs in terms of numbers, levels, contract types and skill profiles	Template designed and tested in a number of programmes. Lack of links to human resources database and overly strategic planning process resulted in decision to approach topic from another angle: link to programme workplans as a first step in 2005
Reduction in number of appeals lodged consequent to application of human resources procedures	44 appeals from staff members in the regions and at headquarters were considered by the headquarters Board of Appeal in the previous biennium	More staff members making use of alternative systems of dispute resolution rather than boards of appeal	Increased use of informal and formal dispute resolution mechanisms to settle staff grievances; 27% reduction in the number of appeals reviewed by the headquarters Board of Appeal
Better balance between male and female staff and in geographical representation	Uneven spread of male and female representation evident throughout Organization. Over recent years, overall percentage remained around 30% for women in professional and higher grades and some Member States consistently unrepresented or underrepresented in WHO workforce	To advance the representation of women towards the 50% target and reduce the number of Member States that have no or few nationals serving as WHO staff	The proportion of women in professional and higher category posts continued to increase, finally standing at 34% The e-recruitment system developed and launched – a significant tool for achieving workforce diversity in the future
Degree of satisfaction of users of human resources services	Lack of final decision and implementation plan of human resources reform proposal created anxiety and frustration among managers and staff, since many human resources policies and procedures were perceived as ineffective, inefficient and unfair	Development and approval of fair, effective and efficient human resources policies and procedures endorsed by senior management, and acceptance by staff of human resources reform proposals	Majority of main reform proposals accepted by WHO's Global Cabinet. A small proportion sent back to the task force for review and reformulation. All proposals then endorsed by the Global Staff/Management Council, thereby providing the necessary acceptance by staff at large

Critical impediments

Internal: three major factors impeded achievement of results in the area of staff development: lack of financial resources available for funding a comprehensive programme, unevenness of capacity in support of programme delivery across the Organization and uneven management capacity to support effective use of individual development plans. In the area of contract reform, a significant amount of time was spent in negotiation, as difficulties were experienced in agreeing on procedures for determining long-term short-term status, and because managers were unwilling to reallocate funds to regularize their staff in view of the increased costs involved.

External: attainment of established targets in the area of recruitment and diversity of gender and geographical representation was hampered by the lack of appropriately qualified candidates from targeted groups.

Relevance and adequacy

The expected results continued to be relevant for staff development. However, the extent of the required change in workplace culture was perhaps underestimated as timelines had to be extended.

Budget adopted by the Health Assembly versus expenditure

The significant increase in expenditure in this area was largely due to the United Nations decision to improve security arrangements for its staff worldwide, resulting in the establishment of the Office of the United Nations Security Coordinator (UNSECOORD) in New York, for which WHO had to contribute its share of the costs. Unbudgeted costs for this activity were reflected under this area of work as it related directly to the safety of all WHO personnel. In addition to the establishment of UNSECOORD, costs for the implementation of many of the human resources reform initiatives developed in the previous biennium had been underestimated, and additional resources had to be allocated.

Total programme budget versus expenditure and expenditure by office (US$ thousand)

Area of work – programme budget	**21 678**
Area of work – expenditure	**40 624**

Expenditure by office:

Headquarters	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
30 259	4 213	940	941	2 329	961	981

Lessons learnt

- There is a need to reach out and increase the involvement of all actors concerned in human resources management issues, both at headquarters and regional and country levels, in order to achieve the cultural shift in management that is desired by WHO.
- Emphasis on staff development should be increased to enhance staff performance. Although it was generally acknowledged during the period under review that this was an important area for improvement, clear commitments were needed in 2004 if results were to be achieved. Effective Organization-wide collaboration in developing and delivering learning programmes needed to be fostered in the following biennium.
- Recruitment sources need to be expanded and contacts should be established with professional associations, public health institutions, collaborating centres and governments in order to ensure wider distribution of WHO employment opportunities.
- The e-recruitment system has proved to be a powerful tool, facilitating the tasks of managers and human resources users alike.
- Policy development needs to be accompanied by realistic, streamlined procedures that are acceptable to the user community.

- Streamlining of administrative procedures and systems eased the work of human resources staff; the global management system will lead to further improvements in this area.
- Regularizing staff contracts brought about an improvement in staff morale. In future, control should be exercised to avoid a repetition of the long-term short-term staff phenomenon and short-term staff numbers should be maintained at acceptable levels.
- Good staff/management relations require constant dialogue and a significant investment in time. Open channels of communication through mechanisms such as the Ombudsman, the Headquarters Grievance Panel and the Staff Counsellor need to be maintained.

FINANCIAL MANAGEMENT

WHO objective(s)

To follow best practice in financial management with integrity and transparency, providing effective and efficient financial administrative support across the Organization for all sources of funds, with relevant financial reporting at all levels, both internally and externally.

Summary of achievements

- Improvements in processing time were achieved through the enhancement of systems and reorganization of work.
- Communications between regions and headquarters were enhanced through the use of videoconferencing and e-mail. Videoconferences were used for staff briefings, staff training courses in regional offices and exchanges of views on policy matters.
- Special projects to provide useful working tools for headquarters and regional offices staff were completed.
- The financial report and audit opinion were accepted by the Health Assembly. Investment earnings exceeded the benchmark owing to sound decisions taken within investment policy parameters.
- Financial reports accurately reflected the financial transactions recorded.
- The integrity of the database was maintained in accordance with WHO's Financial Regulations and Financial Rules, although significant deviations were noted in the WHO Regional Office for Africa.
- Effective and efficient financial management of extrabudgetary resources together with timely and accurate reporting to the donors were noted.
- Global financial reporting deadlines for accounting were met consistently and accurately.
- Member States' collection rate improved for the second consecutive biennium, and arrears of unpaid contributions were reduced.

Illustration of achievements at country, regional or global levels

- Achievements across the various regional offices included devolution of the issuance of obligations, resulting in better services and an improvement in the system used at country level, which now includes expenditure control.
- A continuous effort was made to achieve better global coordination, provision of information and communication by means of yearly global budget and finance meetings and periodic videoconferencing.
- The Regional Office for Africa met its target of reducing by 30% the number of days needed for claim processing. Improvements were made in the Regional Offices for South-East Asia and the Western Pacific through streamlining of those processes.

Achievement of expected results

New, integrated financial management and reporting systems established on the basis of modern business rules and practices that allow staff in all locations and at all levels to have access to the financial information necessary to enable them to meet their objectives

Indicator	Baseline	Target	Achievement
User acceptance sign off on new systems	Various	Various	Substantial progress was made in 2 important systems, interoffice vouchers and imprest – completion expected in 2004

Indicator	Baseline	Target	Achievement
Consistent information across all sources of funds and areas of work	Various	Various	The regional office finance system upload facility used by the Regional Office for Africa since its move back to Brazzaville as an important aspect of its dual-site strategy The interoffice payment request system approved for production in 2003, following extensive tests in the Regional Office for Europe; implementation in other offices now under way Short-term payroll system completed in headquarters; short-term staff payroll provided by this system since mid-2002 File format for health insurance claims system finalized and in use System to automate expenditure contracts in extended pilot mode but not fully approved for general use at headquarters owing to quality problems concerning performance of the contractual partner Introduction of the travel and meetings administration system (TMAS) claims module deferred to allow further business process redesign. Other important TMAS functionality was delivered. TMAS implemented in all regional offices

Financial reporting carried out in accordance with new Financial Regulations and Financial Rules, making it possible to judge the outcome in relation to the budget or plans of actions and expected results for all sources of funds

Indicator	Baseline	Target	Achievement
Alignment in Audited Financial Report of expenditure and budget appropriations	Not aligned	Aligned	Positive response received from the External Auditor
Acceptance by the governing bodies of the biennial financial report and audited financial statements and the interim financial report and statements	Not accepted	Accepted	Financial Report well received by the Health Assembly

Financial resources of the Organization effectively managed within acceptable risk parameters in order to maximize their potential

Indicator	Baseline	Target	Achievement
Level of earnings on liquidity as compared to benchmark	According to approved investment policy	Benchmark per approved investment policy	Benchmark exceeded by 1.6%

Effective and responsive financial administration provided in support of the Organization's new human resources policies

Indicator	Baseline	Target	Achievement
Timeliness and correctness of payments to staff according to their respective compensation package	Various	Various	In general, at headquarters and in the regions, claims (including staff health and other insurances, and education grant) settled in a timely manner. At headquarters, increase in volume of staff health insurance claims exceeded 16%, compared to previous biennium. This led to an increase in processing time as no additional human resources deployed For education grant claims at headquarters, in spite of a 7% increase in claims, processing time improved by about 15% (average 16 days turnaround time). This was achieved mainly through additional assistance during peak periods Salaries (fixed-term worldwide and temporary staff at headquarters) paid according to agreed timetables

Critical impediments

A key requirement for maximizing investment earnings is accurate forecast cashflow information, indicating the amount of cash available for investment, and the length of the period for which it can be invested. Reliable exchange risk management requires accurate information on amounts to be paid (or received) in currencies other than the US dollar. During the period under consideration, systems did not provide accurate forecast information; this meant that a number of short-term decisions were made, which did not necessarily produce optimum investment or currency risk management results.

To mitigate these weaknesses, information on real-time cash position was used and frequent adjustments were made to investment positions. Inadequate resources and antiquated, inflexible systems for processing travel claims were an impediment to claims processing. Significant claim volume increases resulting from an increase in the number of WHO meetings, more duty travel and the addition of significant claims requirements from the Global Fund were not matched by resource increases. Systems and procedures could not cope with the increased volume and complexity of the workload.

Finance systems across the board (both at headquarters and at regional level) needed to be enhanced. As these systems (e.g. new imprest systems, data entry, timeliness of information, UNDP electronic inter-office vouchers) were not in place, productivity gains were not realized. There was a tremendous increase in transaction volume and complexity with no concomitant increase in human resources; staff numbers were inadequate, especially during peak work periods.

Communication channels, both at headquarters and at regional level, became increasingly complex owing to continuous change. As a result, information for management purposes was neither timely nor accurate.

Additional resources needed to be allocated to staff training in order to improve efficiency and effectiveness.

Relevance and adequacy

The expected results and achievements continued to be relevant and measurable and will continue to be applied in future bienniums owing to the constant nature of much of the work concerned. However, as this area of work covers a vast spectrum of accounting and financial management procedures, expected results needed to be further developed and refined in later bienniums.

Budget adopted by the Health Assembly versus expenditure

Total programme budget versus expenditure and expenditure by office (US$ thousand)

Area of work – programme budget	**38 318**
Area of work – expenditure	**38 352**

Expenditure by office:

Headquarters	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
24 484	7 914	1 625	1 162	1 526	1 024	617

Lessons learnt

- Resources and systems need to be improved to absorb increased volume and eliminate inefficiencies in claim processing.
- Weaknesses in the briefing and training of staff on procedures for accounting, and the organization of travel and meetings, also contributed to inefficiency, as staff had to spend additional time explaining travel and per diem rules.
- Timely planning and adherence to realistic time frames are important.
- A better understanding of the roles and responsibilities of senior staff should be instilled.
- A more structured approach to the accounting environment on a global basis is needed.
- Adequate training of staff at all levels is vital, especially in an environment where change is significant and the finance system cumbersome.
- Before WHO embarks on ambitious projects to improve information technology systems, it is important to evaluate the Organization's capacity to implement them and their relationship to and business impact on other systems and users.
- There is a need for realism with regard to the capacity of financial management staff to respond to change when establishing performance criteria for complex products that involve significant changes in ways of working and cross-organizational teamwork.
- Results-based budgeting is a tool for changing the way we approach our work. More needs to be done on priority-setting; adequate time should be allowed for all phases of this activity, with a system of rewards and accountability for performance of the requisite steps, irrespective of the degree of success in delivering the expected results.

INFORMATICS AND INFRASTRUCTURE SERVICES

WHO objective(s)

To design and implement appropriate agreements, tools and procedures to improve communications, sharing of information, and logistics operations throughout the Organization in pursuance of the concept of "one WHO".

Summary of achievements

- Premises and ground security were improved at all established offices.
- More umbrella agreements for commodities were negotiated, resulting in lower per-unit costs across the Organization.
- Efficient and effective support was provided to all technical and governing body meetings.
- Negotiations were concluded with airlines and travel agents for cost-effective travel services, benefiting the Organization as a whole.
- All established offices agreed to develop jointly a rolling capital master plan, involving the upgrading and maintenance of premises so as to enhance their security, and the allocation of resources for real estate projects in a rational and sustainable manner.
- Support was provided to Member States and WHO country and liaison offices in the areas of local and reimbursable procurement, emergency supplies, infrastructure, and logistics and meetings.
- In the area of information and communication technologies (ICT), WHO was encouraged to move towards a more standardized information systems environment by using common application systems rather than "application islands" and by upgrading operating systems to meet current standards.
- Infrastructure was renewed, taking advantage of new technology products and services in order to meet growing end-user requirements for bandwidth, networks, file storage and other computing infrastructure.
- Skills, both of ICT staff and of end-users of ICT facilities and services, were developed.
- With regard to service delivery models, increased emphasis was placed on "business ownership" of application systems, the ICT role being to ensure appropriate and successful technology solutions to support business needs.
- WHO policies for appropriate use of ICT and e-mail usage were put in place.
- In recognition of the growing risks to ICT service delivery posed by viruses and other malicious attacks, more attention was devoted to security risk assessment and establishing mechanisms to guarantee the uninterrupted availability of infrastructure and systems.
- Under the country focus initiative, infrastructure and systems for WHO country and liaison offices were improved, and direct support was provided to Member States in a range of areas, such as telemedicine projects; consultation and needs assessment for information systems; provision of training, logistics and meetings support; and development and deployment of computer applications for health-care management and delivery.

Illustration of achievements at country, regional or global levels

- The WHO Regional Office for Africa was successfully re-established in Brazzaville.
- The automated travel and meetings administration system (TMAS) was successfully launched in all regional offices.
- An electronic commerce e-procurement system (WHO WebBuy) was introduced in various offices, improving procurement support for programme delivery.

Achievement of expected results

Approved plan of action for information technology under implementation

Indicator	Baseline	Target	Achievement
Compatibility of informatics structures, systems and platforms in operation across the Organization	Microsoft operating systems environment across all locations	Microsoft operating systems environment across all locations	Systems platforms: all WHO locations remain Microsoft-based
	Considerable variability in terms of technology available in country offices. For example, some country offices use e-mail facilities of other United Nations bodies or commercial agencies	Establish minimum operating environment for country offices	Little overall change in country office environments, with considerable variation between regions in quality of infrastructure available
	Activity management system and administrative and financial information systems in place as "common" systems, but many local variations introduced throughout the Organization	Establish funding and project governance structure to replace the administrative and finance systems in WHO with a global management system	Funding obtained for global management system project; project director appointed; project team recruitment finalized

Communication system in place linking WHO offices with a view to improving collaboration and coordination through shared information

Indicator	Baseline	Target	Achievement
Secure access by WHO offices to all WHO databases	Headquarters and regional office ICT security function overall poorly resourced (no specialist security personnel, no formal security management programme)	Conduct security risk assessments in 4 regional offices Headquarters and the WHO Regional Office for Africa to work together to improve security of networks	Risk assessments conducted in Regional Offices for Africa, South-East Asia, Europe and the Eastern Mediterranean The Regional Office for Africa network strengthened through sharing of security systems with headquarters

Health supplies of the highest quality at the best price procured for technical programmes and Member States, using mechanisms such as umbrella agreements and electronic commerce to promote a more autonomous method of purchasing

Indicator	Baseline	Target	Achievement
Volume of direct procurement carried out electronically by all WHO offices against centrally negotiated contracts, resulting in lower per-unit costs	Not established	Not established	As the electronic procurement system not established until the end of 2003, volume of direct procurement could not be measured
Level of increase of reimbursable procurement	5.9% of total procurement (US$ 10 812 000) in 2000-2001	Not established	Increase in level of reimbursable procurement to 8.5% of total procurement (US$ 16 751 000), from 5.9% (US$ 10 812 000) in previous biennium

Continuing support provided for programme delivery and WHO's governing bodies in a rational and sustainable manner; appropriate level of logistics services maintained for the smooth operation of established offices

Indicator	Baseline	Target	Achievement
Degree of satisfaction with daily operations of all offices resulting from reliable and effective infrastructure support services	Not established	Not established	Reliable administrative efficiency reviews of operations and proper level of maintenance of the infrastructure confirm that improved support services being provided. However, no surveys conducted to validate degree of customer satisfaction

Critical impediments

Failure to fill vacant posts, lack of good support staff, inadequate office space and lack of adequate tools for monitoring and reporting were the key impediments to achieving the expected results. In the area of ICT, the lack of Organization-wide ICT governance, the absence of system-wide planning to identify accurately what was required of ICT for the delivery of WHO programmes and the lack of adequate and predictable funding for ICT were also critical impediments.

Relevance and adequacy

In general, the expected results were considered relevant and adequate; however, the indicators needed refinement and the area of eHealth (application of ICT in health care) and support for countries generally remained ill-defined.

Budget adopted by the Health Assembly versus expenditure

Total programme budget versus expenditure and expenditure by office (US$ thousand)

Area of work – programme budget	**133 531**
Area of work – expenditure	**150 378**

Expenditure by office:

Headquarters	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
84 542	28 850	3 340	6 776	12 029	8 647	6 194

Lessons learnt

- Growing economic and political problems in some countries heightened security concerns, thus increasing the need to focus resources in this area in 2004-2005 and in 2006-2007.
- Reduced budgets, against a background of stable or increasing operational costs, call for even more conscientious efforts to secure competitive procurements and a quest for innovative ways to reduce costs, such as the sharing of services with neighbouring United Nations or international organizations.
- Improved systems for monitoring and reporting and a more strategic use of resources in support of Organization-wide objectives are needed. This could include the implementation of global systems such as the WHO WebBuy procurement system (e-procurement) and, where possible, negotiations for infrastructure and logistics services that are applicable throughout the Organization (e.g. travel and transportation services, and umbrella agreements for common commodities). This will go a long way towards providing more cost-effective and efficient services across the board.
- A more strategic approach to the use of resources for supporting administrative and technical programme requirements for ICT needs to be put in place. ICT planning needs to be driven by clearly defined Organizational priorities, established through a properly functioning governance mechanism. This strategic approach would include a sharper focus on ICT as a tool for supporting staff in their WHO programme delivery roles.

DIRECTOR-GENERAL'S AND REGIONAL DIRECTORS' OFFICES (INCLUDING AUDIT, OVERSIGHT AND LEGAL)

WHO objective(s)

To direct and inspire all offices of WHO so as to maximize their contribution to achieving significant gains in the health of the populations of Member States, in line with the principles and functions set out in the Constitution.

Summary of achievements

- The Programme budget 2002-2003 was fully implemented financially; there was an increase in extrabudgetary funds; overall, there was a high level of programmatic implementation of the programme budget.
- Strong cross-Organization coordination was maintained for the control of severe acute respiratory syndrome and during negotiations on the WHO framework convention on tobacco control. Although these were both significant achievements, coordination among and support from relevant levels of administration across the Organization also contributed to success.
- Strategic planning for the mid-biennium election of the Director-General and subsequent change of administration allowed for a smooth transition and accomplishment of the objective for the Director-General's Office, as outlined in the programme budget.
- Regional offices noted increasing cooperation with external partners and commitment by governments to health issues.

Achievement of expected results

Resolutions and decisions of WHO's governing bodies fully complied with

Indicator	Baseline	Target	Achievement
Endorsement by governing bodies of regular reports on implementation of resolutions and decisions	Not established	Not established	Broad level of endorsement by governing bodies

Greater coherence and synergy established between the work of the different levels of the Organization in order to achieve "one WHO"

Indicator	Baseline	Target	Achievement
Introduction of Organization-wide reforms promoting "one WHO", e.g. the area of work concept introduced in the present proposed programme budget, and the global policies on human resources and information technology	Not established	Not established	All programmatic aspects of areas of work are linked to expected results described within the programme budget. Collaboration between headquarters and regional offices progressively improving

Optimal administrative, financial and technical practices in use

Indicator	Baseline	Target	Achievement
Production of timely, accurate and useful reports on internal audit and oversight that also identify problems and suggest solutions for identified risks and weaknesses	Not established	Not established	Internal and external audit completed on schedule; recommendations taken into consideration for 2004-2005 planning
Action taken on recommendations of the External Audit	Not established	Not established	All recommendations of the External Auditor were taken into consideration and, where appropriate, acted upon

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

Indicator	Baseline	Target	Achievement
Responsiveness to requests from anywhere within the Organization for legal advice and services	Not established	Not established	The legal status and interests of the Organization were protected during biennium through provision of accurate legal advice and high-quality services. All requests for assistance responded to, whether from headquarters, regional or other offices

Baselines and targets were not established for the Director-General's Office in the Programme budget 2002-2003.

Critical impediments

Problems relating to security, emergency situations and natural disasters, funding constraints and shortage of human resources were noted as critical impediments.

Relevance and adequacy

The expected results were relevant in that they provided overall direction for the scope of work. However, they were limited since much of the work of the Director-General's and Regional Directors' offices is related to driving forward the expected results of other areas of work.

Budget adopted by the Health Assembly versus expenditure

The total expenditure, including the regular budget and other sources for 2002-2003, was US$ 30 954 000 and the total programme budget was US$ 25 028 000.

The difference is largely explained by the additional resources provided by several foundations to fund the transition period of the Director-General elect.

Total programme budget versus expenditure and expenditure by office (US$ thousand)

Area of work – programme budget	**25 028**[1]
Area of work – expenditure	**30 954**[1]

Expenditure by office:

Headquarters	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
20 164[2]	1 884	857	1 629	2 098	2 826	1 496

[1] The area of work approved budget and expenditure also include those under "Director-General's and Regional Directors' Development Programme and Initiatives".

[2] The expenditure at headquarters includes the Director-General's Development Fund, which is actually expended at all levels of the Organization.