I. CHALLENGES, GAPS AND FUTURE NEEDS

1. The Eleventh General Programme of Work 2006-2015 analyses current health challenges. Health is increasingly seen as a key aspect of human security and occupies a prominent place in debates on priorities for development.

2. Over the past 20 years, there have been major gains in life expectancy overall, but there are widening gaps in health; some countries have witnessed reversals of earlier gains, because of such factors as infectious diseases, in particular HIV/AIDS, collapsing health services, and deteriorating social and economic conditions. Prospects for achieving the health-related Millennium Development Goals are not encouraging.

3. The analysis in the General Programme of Work reveals several areas of unrealized potential for improving health, particularly the health of the poor. The missing elements can be summarized as:

- **gaps in social justice**: efforts have been insufficient to ensure equity, health-related human rights and gender equality in health policy and action

- **gaps in responsibility**: the increasing number of sectors, actors and partners involved in health work has led to gaps in accountability and lack of synergy in the coordination of actions to improve health

- **gaps in implementation**: many populations still do not have adequate access to essential public-health interventions; international assistance is often insufficiently aligned to national priorities and systems or harmonized across organizations

- **gaps in knowledge**: knowledge of ways to tackle some of the major health challenges is still weak; research is not always focused on areas of greatest need, and health policy is not always based on best available evidence.

4. Future progress requires strong political will, integrated policies and broad participation. Any significant progress towards achieving the health-related Millennium Development Goals will require action in many sectors and at all levels – individual, community, national, regional and global. The past 10 years have seen a dramatic increase in the number of international partnerships in health. Global health partnerships offer the potential to combine the different strengths of public and private organizations, along with civil society, in tackling health problems. Demands on the United Nations system as a whole are increasing, as are demands for it to reform and show more clearly where it can add value. Academic, industrial, government and nongovernmental research continues to shape the generation of knowledge and its use.

5. In September 2000, the United Nations Millennium Declaration committed countries to a global partnership to reduce poverty and improve health and education, along with promoting peace, human rights, gender equality and environmental sustainability. The seven-point **global health agenda** contained in the Eleventh General Programme of Work reflects this and other agreements adopted by world leaders, and requires action from many different players across the international community, across society and across government, in the following areas:

- investing in health to reduce poverty

- building individual and global health security

- promoting universal coverage, gender equality and health-related human rights

- tackling the determinants of health
• strengthening health systems and equitable access
• harnessing knowledge, science and technology
• strengthening governance, leadership and accountability.
II. LESSONS LEARNT

6. WHO is in a unique position to shape the global public-health agenda through consensus building and binding agreements. Examples of the latter include WHO’s Framework Convention on Tobacco Control and the International Health Regulations (2005). These experiences have enabled the Organization to identify which health issues require a formal negotiated agreement, and which are best approached through consensus building.

7. WHO participates in more than 80 global health partnerships and in numerous global, regional and national health networks. These partnerships and networks contribute to the achievement of WHO’s objectives, and benefit from the Organization’s convening power and technical expertise. WHO continues to learn optimal ways of participating in these partnerships, while maintaining its identity and mandate.

8. In response to increasing demands and current reform of the United Nations system, the Organization will strive to build more effective alliances within both the system and the broader development community. It will work to harmonize the health environment at country level and will engage in the reform process aimed at creating an effective country team under a common United Nations lead.

9. Over the past 60 years WHO has played a prominent role in launching, coordinating, and implementing public-health programmes and initiatives. Some examples are eradication of smallpox, the Expanded Programme on Immunization, the Action Programme on Essential Drugs, the Stop TB Partnership, and efforts to eradicate poliomyelitis, to eliminate leprosy, and to control SARS and avian influenza. WHO has been able to adapt or transform itself in order to meet the needs of specific public-health programmes. For Member States, however, these and other challenges are placing increasing demands on health systems in critical areas related to health workforce, financing, and information. In this regard, work during 2004-2005 revealed the pressing need for greater international consensus about the way health systems should function and how their core functions can be strengthened.

10. Many important determinants of health fall outside of the direct sphere of influence of the health sector. Although WHO continues to draw from experience and develop capacity to work with sectors other than health in order to enhance their understanding of what can realistically be done to improve national health, it is evident that more needs to be done to monitor global trends that are of significance to health in such areas as trade and agriculture. WHO will work with ministries of health to craft appropriate responses.

11. Experience over the last bienniums has shown that clarity and consistency is required on the concept of health equity, which needs to be built into all relevant aspects of WHO’s work. WHO will lead by example, integrating gender in the mainstream of its activities, building it into its technical guidance and normative work, and using sex-disaggregated data in the planning and monitoring of its programmes.

12. WHO will need to be more systematic in its contacts with civil society and industry, including the international health-care and pharmaceutical industries. As scientific advances continue, WHO will be more proactive in leading a dialogue on setting priorities and ethical standards for research. The past years have seen many new initiatives in the area of management and administration. The challenge now lies in the need to consolidate and institutionalize changes already introduced, and to complete reforms without compromising operational capability or staff confidence.

13. Although WHO has been fairly successful in mobilizing resources, a key challenge has been to ensure alignment between the activities planned and the resources mobilized, as voluntary contributions are often earmarked for specific programmes. Internal mechanisms, such as the advisory group on financial resources to channel resources to where they are most needed, require strengthening.
14. In an organization using nearly half its resources on personnel, efficient management of human resources is a key challenge. Personnel policy and practice in the past have not, for example, facilitated the mobility of staff to ensure that the right skills and competencies are always in the right place. The individual performance management system is not being used effectively and needs to be strengthened. The initial work around WHO’s global leadership programme needs to be consolidated.

15. The biennium 2004-2005 saw an unprecedented shift in the pattern of expenditure across the three levels of the Organization, with more resources being put to work in countries and regions. This positive trend needs to be supported by increased managerial skills and capacities in countries and regions and by more robust accountability.

16. Experience with results-based management over the past 10 years has significantly influenced the Medium-term strategic plan, and some key lessons learnt are reflected in definition of its priorities, strategic objectives and expected results.

17. First, it has become clear that a two-year time frame is inadequate to reflect the work of the Organization in many aspects of health. Successful activities require a significantly longer period to achieve the results expected. A medium-term plan provides an opportunity to adopt a more strategic and realistic approach to planning and the achievement of health outcomes.

18. Second, the plan is structured so as to create synergies between the different programmes and levels of WHO. The former planning structure of areas of work tended to compartmentalization, as organizational structures, especially at headquarters, reflected those areas. Although such a division of labour facilitated resource allocation, it limited opportunities for collaboration across the Secretariat. The move to a smaller number of strategic objectives will significantly facilitate such collaboration. The strategic objectives are not mutually exclusive; they encourage differing but complementary perspectives for tackling common priorities.

19. Third, achievement of desired health outcomes is rarely attributable to a single intervention, or work by any one organization; the plan highlights work conducted within many collaborative arrangements. WHO will need to provide forums for engaging in dialogue with the increasing number and type of entities involved in health and development, including systematic contact with civil society and industry, including the international health-care and pharmaceutical industries.

20. Lastly, new business processes are required to support new ways of working. Greater dependence on voluntary contributions, increased internal collaboration across organizational structures, decentralization of resources, bigger role played in operational aspects of health emergencies and disease outbreaks, and the growth of health-related legal frameworks, all require modern and flexible management systems. Introduction of the Global Management System and related enterprise resource planning will back up these innovations.
III. STRATEGIC DIRECTION FOR 2008-2013

21. During the six years 2008–2013, WHO will continue to provide leadership in matters of public health, optimizing its impartiality and near universal membership. Guidance from governments through the Executive Board, the Health Assembly and the regional committees ensures legitimacy for the work of the Organization; in turn, the Secretariat’s reporting to the governing bodies ensures its accountability for implementation. WHO’s convening power enables diverse groups to stimulate collective action worldwide.

22. WHO’s role in tackling diseases is unparalleled, whether it acts by marshalling the necessary scientific evidence, promoting global strategies for eradication, elimination or prevention, or by identifying and helping to control outbreaks.

23. WHO will promote evidence-based debate, analysis and framing of policy development for health through the work of the Secretariat, expert and advisory groups, collaborating centres, and the numerous formal and informal networks in which it participates.

24. The structure of WHO’s Secretariat assures involvement with countries. Headquarters focuses on issues of global concern and technical backstopping for regions and countries. Regional offices focus on technical support and building of national capacities. WHO’s presence in countries allows it to have a close relationship with ministries of health and with its partners inside and outside government. The Organization collaborates closely with bodies of the United Nations system and provides channels for emergency support.

25. Through its decentralized structure and close working relations with governments, the Secretariat is able to gather health information and monitor trends over time, across countries, regions, and worldwide.

26. Within the framework of the Eleventh General Programme of Work, the pressing need to address the global burden of communicable diseases is reflected in the formulation of several WHO strategies for expanding interventions to reduce the burden of HIV, tuberculosis, malaria and vaccine-preventable diseases, and to make rapid progress in eradicating, eliminating or controlling diseases such as poliomyelitis, leprosy, dracunculiasis, onchocerciasis, schistosomiasis, and lymphatic filariasis. Implementation of the International Health Regulations (2005) will provide a framework for strengthening surveillance of, preparedness for, and response to, communicable diseases.

27. Several high-level strategies endorsed by Member States will guide the work of the Organization in improving sexual and reproductive health and child health, increasing immunization coverage, and tackling noncommunicable diseases, such as cancer and cardiovascular diseases. Interventions related to the health of mothers and children will be linked through a continuum of care throughout the life-cycle.

28. Provision of support to Member States is carried out largely in collaboration with other organizations of the United Nations system and partners. In the above-mentioned areas it involves mostly technical assistance – direct implementation by WHO is rarely needed or appropriate.

29. WHO has established infrastructures and mechanisms for disease-outbreak alert and response, and for addressing other public health emergencies when they arise. Clear responsibilities and time frames for action for WHO, both Member States and Secretariat, are set out in the International Health Regulations (2005). New in the Regulations are provisions for detecting and responding to threats from emerging diseases and the central importance given to surveillance. Once poliomyelitis is eradicated, the infrastructure established to ensure surveillance and programme delivery will adapt to the growing needs for outbreak alert and response, and disease surveillance.
30. WHO also has well-tested mechanisms for mitigating the health consequences of emergencies arising from conflicts and natural disasters. In this regard, WHO, as the lead agency for the United Nations health cluster, will continue work in the context of reform of humanitarian action in the United Nations system, and to strengthen its partnerships with other organizations of the system, national institutions, and nongovernmental organizations.

31. The report of the Commission on Social Determinants of Health, due in early 2008, will provide an agenda for tackling the factors that influence the health of populations, highlighting ways in which the Organization can effectively collaborate with sectors other than health on the basis of a shared commitment to achieving equity and reducing poverty.

32. Population-based, environmental and behavioural approaches will be adopted to reduce such risks to health as obesity, high blood-pressure, harmful use of alcohol, and unsafe sex. Measures consistent with the Framework Convention on Tobacco Control will back up work to reduce tobacco consumption. WHO will also consolidate and expand its work on health promotion, nutrition, food safety, food security, and prevention of injury and violence.

33. Universal coverage with effective public-health interventions depends on well-functioning health systems. *The world health report 2006* highlights the crisis in the global health workforce and identifies steps that countries and partners need to take if health commitments and targets such as those in the Millennium Development Goals are to be met.¹ WHO also will enhance its capacity to provide support to Member States for putting in place strategies to improve other key components of health systems related to financing, information, research and essential medicines and technologies. These strategies will be fully integrated and coordinated with health systems, and will build on opportunities and resources included in priority programmes such as HIV/AIDS and immunization, and maternal health.

34. The Eleventh General Programme of Work emphasizes the increased number of stakeholders working in health at both national and international levels and the need for WHO to respond flexibly and rapidly to this evolution. WHO will use its convening power to stimulate action across sectors, while building the capacity of governments to take on this role nationally. It will take the lead in promoting effective partnerships for health, in shaping the global health environment, and operationalizing reform of the United Nations system at global, regional and country levels. To meet these challenges, WHO will continue to evolve as a learning organization and to strengthen its managerial capacity.

35. The core functions of WHO will guide the work of the Secretariat in the five areas described above, influence approaches for achieving the strategic objectives, and provide a framework for assuring consistency and output at global, regional and country levels. The core functions are:

- providing **leadership** on matters critical to health and engaging in partnerships where joint action is needed
- shaping the **research** agenda, and stimulating the generation, dissemination and application of valuable knowledge
- setting **norms and standards**, and promoting and monitoring their implementation
- articulating ethical and evidence-based **policy options**

• providing **technical support**, catalysing change and building sustainable institutional capacity

• monitoring the health situation and assessing health trends.

36. Expected achievements over the period of the Medium-term strategic plan are described in 16 **strategic objectives** set out below, which reflect the results-based management framework, and provide clear, measurable and budgeted expected results for the Organization. They promote collaboration across disease-specific programmes by capturing the multiple links among the determinants of health and health outcomes, policies, systems and technologies.

1. To reduce the health, social and economic burden of communicable diseases

2. To combat HIV/AIDS, tuberculosis and malaria

3. To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries

4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals

5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact

6. To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex

7. To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches

8. To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health

9. To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development

10. To improve the organization, management and delivery of health services

11. To strengthen leadership, governance and the evidence base of health systems

12. To ensure improved access, quality and use of medical products and technologies

13. To ensure an available, competent, responsive and productive health workforce in order to improve health outcomes

14. To extend social protection through fair, adequate and sustainable financing

15. To provide leadership, strengthen governance and foster partnership and collaboration with countries in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work
16. To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively.

Flexibility and responsiveness are essential to address effectively the rapid changes foreseen in health needs and opportunities. WHO will continue to monitor trends, and modify plans and expected results accordingly.
IV. WHO’S FRAMEWORK FOR RESULTS-BASED MANAGEMENT

37. The Eleventh General Programme of Work provides a long-term perspective on the determinants of health and the measures required for improving health while setting forth a global health agenda.\(^1\)

38. The Medium-term strategic plan 2008-2013 stems from the General Programme of Work. It will provide the strategic direction for the Organization for the six-year period, advancing the global health agenda through a multi-biennial framework. It will guide preparation of three biennial programme budgets and operational plans through each biennium.

39. The 16 strategic objectives set out above take into account the complementarities between strategic objectives. For example, they recognize that for health interventions effectively to achieve better health outcomes and reduce the burden of disease, it is as essential to strengthen health systems as it is to develop norms and standards for specific diseases and work with other sectors in tackling determinants of health. These broad strategic objectives provide a flexible programme structure that better reflects the needs of countries and regions. They facilitate collaboration throughout the Organization, through Organization-wide teams built around strategic objectives.

Figure 1. Medium-term strategic plan

40. For each strategic objective, the plan identifies a series of Organization-wide expected results for which the Secretariat will be accountable over the three bienniums. It provides indicators, targets and resources required for their achievement.

41. The plan requires technically sound approaches and an enabling environment to support efficient and effective implementation. The enabling environment includes responsive, flexible and efficient internal management of the Organization, and the ability to work strategically with a wide range of partners. Robust accountability mechanisms ensure integrity of the assessment of the Organization’s performance and management of its resources.

42. The Proposed programme budget makes the Medium-term strategic plan operational, identifying the scope of activities and specifying achievements expected in the two years. It provides

\(^1\) Document A59/25.
for each of the Organization-wide results the targets for 2008-2009 and the resources required for their achievement.

43. The Proposed programme budget is the basis for operational planning. During the operational planning phase, country and regional offices and headquarters identify their contribution towards achieving the Organization-wide expected results. These operational plans, also referred to as workplans, establish the specific products and services that the Secretariat will provide in order to meet its commitments set out in the strategic plan and biennial budgets. In these workplans, time frames and responsibility and accountability for delivering products and services are identified for each organizational entity and level, thus linking strategic objectives and Organization-wide expected results with the organizational structure.

44. Comprehensive reform is under way to improve management of the Organization, the main thrust of which is set out in strategic objective 16. It is captured also in an Organization-wide guide, which is continuously under review to ensure that it effectively addresses the changing needs of the Organization. Managerial reform also is a standing item on the agenda of the Programme, Budget and Administration Committee of the Executive Board. The scope of these reforms spans the results-based management framework, management of financial resources, provision of effective operational support, and assurance of robust accountability.

45. The Organization faces the challenge of working efficiently across different, but related, programme areas, and across its three levels. Organizational processes such as joint planning and peer reviews can facilitate this work, together with collaborative methods that promote interdependence, such as greater staff mobility and rotation across the Organization.

46. As a decentralized organization, efficient and effective programme management requires balancing the need to assure an Organization-wide approach and responsibility, and to recognize regional specificities. Transparent governance mechanisms and common systems and approaches across the Organization will be increasingly adopted, linked to further devolution of decision-making.

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and greater accountability. This trend will be facilitated by moving from managing through tight bureaucratic controls to greater reliance on monitoring.

47. Managers will play a crucial role, as they drive change within the Organization. Managers must foster integration and team work, ensure the effective use of resources, build and promote partnerships across the Organization, and provide a model of ethical behaviour. They also manage performance of both programmes and individual staff. WHO’s Global Leadership Programme aims to provide support for these aspects of their work.

48. Accountability is a critical element supporting the results-based management approach. WHO has adopted an accountability framework that brings together aspects of responsibility, accountability and authority, based on overarching principles that ensure good governance. These include having well-understood organizational values, behaviours and aims, managing risk competently, and reporting transparently to all stakeholders.

49. Mechanisms to ensure accountability and integrity in the work of the Organization include programme monitoring and assessment; programme-related evaluations; internal audits; an independent external auditor who reports directly to the Health Assembly; staff and financial regulations and rules; ombudsman functions; mechanisms to ensure internal justice, annual reporting on financial and human resources to governing bodies; and a performance evaluation system for staff. Increased attention is being paid to these important functions, both internally and by key stakeholders.
V. EFFECTIVE FINANCING OF THE MEDIUM-TERM STRATEGIC PLAN

50. To achieve the strategic objectives as set out in the Medium-term strategic plan requires effective financing. The draft plan has been costed with an overall budget of US$ 14 000 million over the period of six years and a budget of US$ 4263 million over the two years of the proposed programme budget 2008–2009.\(^1\) On the basis of expected expenditure in the biennium 2006–2007, the budget proposed would increase by 16%. This increase is justified by the ambitious yet realistic targets to be achieved in response to the growing demands and expectations made on the Organization.

51. The increase is primarily intended to address the following priorities:

- implementing the International Health Regulations (2005), so as to respond rapidly to outbreaks of known and new diseases and emergencies, building on eradication of poliomyelitis to develop an effective surveillance and response infrastructure
- addressing the epidemic of chronic noncommunicable diseases, with an emphasis on measures to reduce risk factors such as tobacco consumption, poor diet, and physical inactivity
- using the future report of the Commission on Social Determinants of Health to address the broader aspects of health and its interaction with other sectors
- reducing maternal and child mortality, by aiming at universal access to, and coverage with, effective interventions, and strengthening of health services
- improving health systems, focusing on human resources, financing and health information.

Sources of income and financial plan

52. WHO has adopted a results-based management approach to determining resource requirements, with an integrated budget comprising all sources of funding. The costs of achieving specific results in a given time frame are therefore financed with funds from different sources.

53. WHO receives its funding principally through assessed contributions from Member States and voluntary contributions. Assessed contributions are gradually becoming a smaller proportion of the total resources received, and reliance is increasing on voluntary contributions provided by a limited number of partners and donors, small and large.

54. Financing the Medium-term strategic plan requires efficient management of the different sources of income, to ensure that resources are made available where they are needed, for the purpose they are needed, and when they are needed. Although WHO has been fairly successful in mobilizing resources, a key challenge remains, that of ensuring alignment between the activities planned and the resources mobilized. Despite improvements, more efforts will be required to avoid situations where funds lie idle or are underutilized in one programme or location while they are acutely needed in another. This will require contributors of voluntary funds to provide their resources in a more flexible and predictable manner, and the Organization to strengthen mechanisms such as the advisory group on financial resources that recommends to the Director-General allocation of resources in a participatory and transparent manner in order to finance agreed Organization-wide work plans.

\(^1\) The proposed 2008–2009 budget includes major partnerships and special programmes such as the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases; the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction; and others, as was the case in the Programme budget 2006–2007.
For the next six-year period, WHO will continue to finance the Medium-term strategic plan through these sources, but will move towards categorizing them according to three sources of funds: **assessed** contributions, including miscellaneous income, **negotiated core voluntary** contributions, and **other voluntary** contributions. This acknowledges the continuing work with partners and donors better to align voluntary contributions with the achievement of results as set out in the Programme budget.

**Assessed contribution and miscellaneous income**

An assessed contribution amounting to US$ 970 million is proposed for the biennium 2008-2009 in order to maintain a reasonable balance between the two sources of funding. This represents an increase of 8.6% compared to the biennium 2006–2007. Even at this level, assessed contributions would account for only 23% of the overall budget in 2008–2009.

Miscellaneous income is derived mainly from interest earnings on assessed-contribution funds, collections of arrears of assessed contributions, and unspent assessed contributions at the end of a biennium. The overall level of miscellaneous income is expected to increase to approximately US$ 30 million per biennium.

Thus the total of assessed contribution and miscellaneous income proposed for the Programme budget 2008–2009 is US$ 1000 million. The aim is for assessed contributions to finance one third of the total biennial budget by the end of the six-year period. Assuming that miscellaneous income remains constant, reflecting a more efficient and effective Organization, this would mean a gradual increase of assessed contributions in each of the three bienniums.

**Negotiated core voluntary contributions**

In the biennium 2004–2005 about 74% of the total income came from voluntary contributions. Less than a dozen different sources accounted for more than 75% of all voluntary contributions received, with the remaining 25% coming from more than 420 different sources.

Most voluntary contributions are received for development work and humanitarian assistance, and come mainly from bilateral and multilateral development agencies and a few private foundations. Although all resources are welcome and indeed essential to execute WHO’s programme of work, the manner in which they are provided can pose a challenge to ensuring proper alignment between the programme budget and its implementation. Further, administering thousands of separate agreements requiring specific reporting significantly increases the transaction costs to the Organization.

Working with key partners and donors, WHO is moving towards acquiring a larger share of predictable, unearmarked core voluntary contributions, also referred to as negotiated core voluntary contributions. This would help align resources to the priorities of the Organization as determined by the governing bodies through the Programme budget, meet critical funding gaps, and improve implementation of the programme budget by making availability of resources more predictable.

Core negotiated voluntary contributions are those that provide predictable amounts for a set length of time, aligned to strategic objectives or Organization-wide expected results in the Medium-term strategic plan, and are negotiated at an Organization-wide level. Their reporting requirements follow the WHO reporting norms through the results-based framework and the official audited financial reports.

Currently, slightly more than 10% of voluntary contributions can be considered as negotiated core voluntary contributions. WHO will seek to increase the share of core voluntary contributions to a third of total resources by 2013. For the biennium 2008–2009, the aim is to double the level of core voluntary contributions from current expectations to roughly US$ 600 million, representing about 14% of total resources.
Other voluntary contributions

64. Currently the Organization is financed largely from voluntary contributions intended for a specific purpose. For the biennium 2008-2009, after taking into account the regular budget and negotiated core voluntary contributions, about US$ 2600 million in other voluntary contributions will need to be raised. On the basis of past trends this is a realistic target.

65. A high degree of specificity is attached to much of the voluntary funding, including approximately US$ 1000 million related to partnerships or specific appeals. Such financing includes partnerships hosted by WHO, response to emergencies and epidemic outbreaks, special disease-eradication campaigns, and procurement on behalf of Member States. These resources are an important part of the financing of priority programmes of the Organization.

66. Table 1 below summarizes WHO’s financial plan over the six-year period. Beyond the biennium 2008-2009, figures are indicative only and may be revised during preparation of the next biennial cycle. The table shows the Programme budget 2006–2007 and the currently higher expected expenditures. Since adoption of the Programme budget, overall expected expenditures have in effect risen because of increased activity in the areas of pandemic-influenza preparedness and WHO’s participation in both existing and new partnerships such as the Global Drug Facility of the Stop TB Partnership, the World Alliance for Patient Safety, the Alliance for Health Policy and Systems Research, and several other partnerships. Such expenditures should be considered as the de facto baseline against which the Proposed programme budget should be compared.

Table 1. Financing of the Proposed programme budget: evolution during the period of the Medium-term strategic plan (US$ million)

<table>
<thead>
<tr>
<th>Sources of income</th>
<th>Baseline, 2006–2007</th>
<th>Proposed programme budgets, 2008–2013</th>
<th>Increase over expected expenditure 2006–2007 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessed contributions 2008–2009</td>
<td>893</td>
<td>893</td>
<td>970</td>
</tr>
<tr>
<td>Miscellaneous income</td>
<td>22</td>
<td>22</td>
<td>30</td>
</tr>
<tr>
<td><strong>Total assessed contribution</strong></td>
<td><strong>915</strong></td>
<td><strong>915</strong></td>
<td><strong>1 000</strong></td>
</tr>
<tr>
<td>Negotiated core</td>
<td>---</td>
<td>300</td>
<td>600</td>
</tr>
<tr>
<td>Other voluntary</td>
<td>---</td>
<td>2 455</td>
<td>2 663</td>
</tr>
<tr>
<td><strong>Total voluntary contributions</strong></td>
<td><strong>2 398</strong></td>
<td><strong>2 755</strong></td>
<td><strong>3 263</strong></td>
</tr>
<tr>
<td><strong>Total financing</strong></td>
<td><strong>3 313</strong></td>
<td><strong>3 670</strong></td>
<td><strong>4 263</strong></td>
</tr>
</tbody>
</table>
Proposed budgets

67. Calculated on the basis of the estimated cost of meeting the Organization-wide expected results, the proposed programme budget, broken down by location and main source of funding, is indicated in Table 2 below.

Table 2. Proposed programme budget 2008–2009 compared to Programme budget 2006–2007 by office and main source of funding (US$ million)

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td></td>
<td>Assessed contribution a</td>
<td>Voluntary contribution</td>
</tr>
<tr>
<td>Regional office:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Africa</td>
<td>204</td>
<td>746</td>
</tr>
<tr>
<td>The Americas</td>
<td>78</td>
<td>121</td>
</tr>
<tr>
<td>South-East Asia</td>
<td>99</td>
<td>258</td>
</tr>
<tr>
<td>Europe</td>
<td>58</td>
<td>142</td>
</tr>
<tr>
<td>Eastern Mediterranean</td>
<td>87</td>
<td>294</td>
</tr>
<tr>
<td>Western Pacific</td>
<td>77</td>
<td>156</td>
</tr>
<tr>
<td>Headquarters</td>
<td>312</td>
<td>681</td>
</tr>
<tr>
<td>Total</td>
<td>915</td>
<td>2 398</td>
</tr>
</tbody>
</table>

a Includes miscellaneous income.

68. In pursuance of the Organization’s strategy to strengthen first-line support to countries with adequate back-up at regional and global levels, most of the budget will be spent in regions and countries, while maintaining headquarters functions, particularly in the normative areas.

69. Resource distribution between regions reflect programme needs that follow a results-based approach, and are in line with indications from the validation mechanism for strategic resource allocation reviewed by the Executive Board.1 Subsequent biennial programme budgets will reflect programmatic changes between regions, but should remain relatively similar over the six-year period. Figure 3 below illustrates distribution of the budget between regional offices and headquarters. Table 3 below shows the shift in distribution from 2006–2007 to 2008–2009, excluding the poliomyelitis eradication initiative and WHO’s response to emergencies, so as to be comparable with the validation mechanism.

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1 See document EB118/2006/REC/2, Summary record of the fourth meeting, section 4.
Figure 3. Budget distribution between regional offices and headquarters

Table 3. Budget distribution between regional offices and headquarters$^a$

(US$ million)

<table>
<thead>
<tr>
<th>Location</th>
<th>Approved 2006–2007</th>
<th>Percentage of total</th>
<th>Proposed 2008–2009</th>
<th>Percentage of total</th>
<th>Validation mechanism Ranges as a percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Minimum</td>
</tr>
<tr>
<td>Regional office:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Africa</td>
<td>768.9</td>
<td>26.5</td>
<td>986.7</td>
<td>26.0</td>
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<td>250.9</td>
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<td>1 132.5</td>
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<td><strong>2 902.3</strong></td>
<td><strong>100.0</strong></td>
<td><strong>3 790.1</strong></td>
<td><strong>100.0</strong></td>
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$^a$ Excludes the Global Poliomyelitis Eradication Initiative and WHO’s response to emergencies, so as to facilitate comparison with the validation mechanism.
VI. MONITORING AND EVALUATION

70. A number of instruments within WHO’s results-based management framework serve to monitor, assess, evaluate and deal with potential issues related to performance of the Medium-term strategic plan and associated programme budgets.

71. Programmatic and financial implementation is monitored on the basis of operational plans (workplans) at least every six months throughout the biennium. This serves to review and adjust where needed the implementation of specific activities in light of the programmatic and financial situation.

72. An Organization-wide mid-term review is carried out at the end of the first year of each biennium, which assesses progress at each WHO office towards achievement of the specific results for which each is accountable. The mid-term review complements the unaudited financial report.

73. Programme budget performance is assessed at the end of the biennium and complements the audited financial report submitted at the same time. The assessment report provides an Organization-wide summary of the programmatic performance of the Secretariat, along with the broader lessons learnt across the Organization.

74. The Medium-term strategic plan is monitored through the assessment of programme budget performance. At the end of the six-year period, the extent to which the 16 strategic objectives in the Medium-term strategic plan have been achieved will be assessed. Data on the strategic-objective indicators will be collected to establish the degree to which the targets have been reached. Performance will be analysed and the main achievements in delivery of the strategic objectives, factors contributing to, or impeding, success, and lessons learnt will be summarized to help in drawing up subsequent strategic plans.

75. The framework also includes the periodic evaluation of WHO’s programmes, which assess the outcomes of WHO’s work along the lines of thematic, programmatic or country evaluations.

76. Mechanisms such as peer reviews are employed in both the planning and monitoring phases of results-based management so as to ensure a high level of quality throughout the Organization. Collective reviews by senior management, along with the governing bodies, also serve to identify emerging needs, potential performance issues, and ensuing re-prioritization during the six-year period.

77. The General Programme of Work will also be monitored. Priorities will be assessed in depth, and WHO’s core functions monitored to ensure their continuing relevance, and the quality and influence of WHO’s work.