WORLD HEALTH ORGANIZATION

FIFTY-NINTH WORLD HEALTH ASSEMBLY **A59/30**
Provisional agenda item 15.3 **24 April 2006**

Programme budget 2004-2005: performance assessment

OVERVIEW

1. This overview provides a summary of results achieved during the biennium 2004-2005, and of key constraints and challenges. The performance assessment of the Programme budget 2004-2005 is part of WHO's results-based management and accountability framework. The Programme budget was operationalized on the basis of a philosophy of "doing the right things, in the right places, in the right way" under the overarching principle of working with countries and building national capacity.

2. The biennium 2004-2005 was characterized by an increase in the demands placed on Member States, the Secretariat and partners working in global health. Among the many challenges to be faced were: strengthening health systems; providing access to medicines to the growing number of persons with HIV/AIDS, tuberculosis and malaria; responding to the renewed threat of new, emerging and existing communicable diseases and to emergency situations; accelerating progress towards achievement of the Millennium Development Goals – including improving the health of women and children; responding to the growing burden of noncommunicable diseases and mental disorders; recognizing the links between poverty and ill-health; and understanding the impact of environmental and social determinants on health development.

3. The biennium saw significant progress in WHO's support for Member States' efforts to meet several of these challenges. Measures included scaling up access to antiretroviral medicines for HIV/AIDS through the "3 by 5" initiative; moving closer towards the eradication of poliomyelitis; adoption of the International Health Regulations (2005); and implementing the WHO Framework Convention on Tobacco Control. During the biennium, the world faced several major crises such as the Indian Ocean earthquakes and tsunamis, the south Asia earthquake, the crisis in Darfur, Sudan, and the emerging threat of avian influenza.

4. In working towards achieving health goals the Organization continues to reach out to other partners, including those in civil society and the private sector, and strives to play an effective role within the United Nations system: WHO continued to enter into creative and innovative partnerships with the various key players in the field of human development and health security.

5. There were increased demands for the Organization to work in ways that maximize its impact, with better cohesion between country teams, regional offices and headquarters departments. These called for WHO to be more effective and efficient, more accountable, more transparent and more receptive to a changing world. For the Secretariat, the biennium 2004-2005 was characterized by reforms to enhance its efficiency and effectiveness.

6. The achievements of the Organization in the biennium are presented under five headings: improving health outcomes; responding to outbreaks and emergencies; tackling health determinants; strengthening health systems; and focusing on results-based management.

Improving health outcomes

7. The WHO/UNAIDS "3 by 5" initiative with the goal of putting three million people living with HIV/AIDS on antiretroviral treatment by the end of 2005 - has provided clear evidence that it is possible to deliver such treatment in resource-limited settings and that major expansion of treatment, based on public health principles, is feasible in some of the poorest and most affected countries. The number of people receiving antiretroviral treatment in low- and middle-income countries increased – from 400 000 in December 2003 to more than 1.3 million in December 2005. WHO remains committed to achieving universal access.

8. Some 3205 cases of poliomyelitis were reported in 24 countries in 2004-2005 (compared with 2401 in 16 countries in 2002-2003). Health ministers of the remaining poliomyelitis-affected countries signed the Geneva Declaration for the Eradication of Poliomyelitis in January 2004, committing themselves to the intensification and completion of eradication activities globally. More than 25 countries across Africa, the Middle East and Asia restarted mass poliomyelitis immunization campaigns to either halt or prevent the further national and international spread of a multicountry epidemic that originated in northern Nigeria. Measles deaths throughout the world decreased to an estimated 454 000 in 2004 from 871 000 in 1999, a reduction of 48%. This progress can be attributed in part to the implementation of the WHO/UNICEF Comprehensive Strategy for Sustainable Measles Mortality Reduction by the most affected countries, especially those in Africa, where measles deaths fell by 60 %.

9. The strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health was endorsed by the Health Assembly in resolution WHA57.12 in May 2004. Evidence-based normative tools and guidelines on reproductive health were published and disseminated to regions and countries. The clinical interface between sexual and reproductive health and HIV/AIDS became an important focus of WHO in the area of reproductive health.

10. Technical support was provided to countries to increase capacity for improving the quality of care, and to enhance equitable access to, and use of, maternal and newborn health. Guidelines were developed to support the integrated management of pregnancy and childbirth, and documentation on improving access to good-quality care in family planning was revised to incorporate the latest scientific developments.

11. Thirty-two countries were provided with support on translating recommendations of the United Nations Committee on the Rights of the Child into action. With the support of WHO, increasing numbers of countries are adopting key interventions for child survival; 67 countries have expanded geographical coverage of the Integrated Management of Childhood Illness Strategy; 39 are implementing the Global Strategy for Infant and Young Child Feeding, and seven are applying WHO's strategic approach to HIV and young people.

12. In 2005, a new strategy to stop tuberculosis (Stop TB), built around DOTS, was formulated and the Stop TB Partnership's Global Drug Facility delivered more than 2.4 million patient treatments to 65 countries. The first tuberculosis vaccine candidates progressed from preclinical development to

clinical evaluation in human beings and preliminary scientific results gave hope that new effective tuberculosis vaccines may be introduced within the next 10 years.

13. WHO procured and distributed 1.3 million insecticide-treated nets, protecting about 2.5 million vulnerable people from mosquitoes that transmit malaria. Tens of millions of nets were procured and distributed by other partners and countries. During the biennium, 29 additional endemic countries shifted to artemisinin-based combination therapies, bringing the total to 52. In 2005, 30 million doses were procured by endemic countries, compared to four million in 2004.

14. The number of countries endemic for dracunculiasis was reduced from 13 in 2003 to nine in 2005. A memorandum of understanding was signed with the manufacturer guaranteeing free supply of multi-drug therapy for leprosy worldwide up to the end of 2010. An integrated strategy for vector control for public health was developed and, for the first time, oral cholera vaccines were used as a humanitarian intervention in southern Darfur and in the tsunami-affected province of Aceh, Indonesia. The clinical development of the meningococcal group A conjugate vaccine in adult volunteers began, raising the prospect that epidemic meningitis in the African meningitis belt may be eliminated.

Responding to outbreaks and emergencies

15. By resolution WHA58.3, the Health Assembly adopted the International Health Regulations (2005), which provide a framework for global alert and response to public health emergencies of international concern and for strengthening national core capacities. WHO's epidemic alert and response operations were scaled up, the Global Outbreak Alert and Response Network expanded and the WHO Strategic Health Operations Centre became fully operational. WHO provided effective leadership in surveillance, risk assessment, scientific research, capacity strengthening and operational response to the emerging threat of avian influenza and systematic preparedness for a possible influenza pandemic.

16. The biennium was marked by a series of natural disasters, the most prominent of which were the Indian Ocean earthquakes and tsunamis of 26 December 2004, which prompted an unprecedented international response and presented WHO and its partners with extraordinary logistic challenges. WHO also provided prompt support to the Government of Pakistan in the aftermath of the devastating south Asia earthquake. In addition to supporting the immediate disaster relief efforts in response to these emergencies, WHO also provided support for rehabilitation of services for maternal and newborn health. Other achievements include the health survey carried out by WHO in Sudan in August 2004, which was instrumental in bringing the Darfur crisis into the international spotlight.

Tackling health determinants

17. History was made on 27 February 2005 when the WHO Framework Convention on Tobacco Control entered into force. In November 2005 the Framework Convention received its hundredth ratification, a milestone for the international health community.

18. The Protocol on Water and Health to the 1992 Convention on the Protection and Use of Transboundary Water Courses and International Lakes, elaborated and supported jointly by WHO and the United Nations Economic Commission for Europe, is the world's first legally binding international instrument in the fight against water-related diseases. The Protocol entered into force on 4 August 2005 and had 17 Parties as of 31 December 2005. Marking the start of the International Decade for Action: "Water for Life" 2005-2015, WHO and UNICEF launched a report to boost efforts to reach the Millennium Development Goal target for safe drinking water and basic sanitation. The

report indicating what remains to be done was viewed internationally as a major contribution to promoting access to safe drinking water and sanitation for the thousands of millions of people who are highly exposed to risks of water-related diseases.

19. The WHO International Food Safety Authorities Network (INFOSAN) was created to minimize the consequences of food-borne disease outbreaks; it includes an emergency component and already has 145 participating Member States. To facilitate greater participation by developing countries in the WHO/FAO Codex Alimentarius Commission, WHO and FAO created the Codex Trust Fund and had mobilized US$ 4 million for the fund by the end of 2005.

20. By resolution WHA57.17, the Health Assembly adopted the WHO Global Strategy on Diet, Physical Activity and Health. The launch of a WHO report on prevention of chronic diseases marked the start of a major initiative to raise awareness of the growing global epidemic of chronic diseases.[1]

21. A WHO Multi-country Study on Women's Health and Domestic Violence against Women completed in 2005 shows that violence against women is widespread, with far-reaching health consequences. The study draws on data from more than 24000 women interviewed in 10 countries.

22. At the Fifty-seventh World Health Assembly, the Director-General announced the formation of a Commission on Social Determinants of Health, a body aimed at addressing the social factors that have an impact on health. WHO also coordinated the technical input and writing of an unprecedented international report on the complex links between the preservation of healthy and biodiverse natural ecosystems and human health.[2] The report contributes to the broader Millennium Ecosystem Assessment, a four-year series of studies and reports involving more than 1300 scientists, considering impacts on human well-being, past, present and future.

Strengthening health systems

23. At the "Montreux Challenge: Making Health Systems Work" meeting hosted by WHO, representatives of all major global programmes and initiatives on health systems, funding agencies, health-systems experts and government policy-makers sought to reach agreement on what constitutes health-system strengthening and identify ways to harmonize disease-specific and more general approaches to health-system development. They also roughed out a rough road map for taking forward discrete elements of this agenda so as to ease the most binding constraints on health systems and accelerate progress towards attaining global health goals.

24. The crisis in human resources for health was high on the agenda of the third High-Level Forum on the Health MDGs (Paris, November 2005) coordinated by WHO and the World Bank and attended by ministers and senior officials from developing countries, heads of bilateral and multilateral agencies, and other partners. The participants agreed on the need to forge a formal global alliance, in which WHO is to play a vital role, dedicated to tackling the crisis in human resources in health.

25. WHO's agenda on research policy and promotion moved forward at the Ministerial Summit on Health Research in Mexico City in November 2004, at which health ministers and other representatives from 58 countries called for a greater commitment by all nations to health research.

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[1] *Preventing chronic diseases: a vital investment*, Geneva, World Health Organization, 2005.

[2] *Ecosystems and Human Well-being: Health Synthesis*, Geneva, World Health Organization, 2005.

26. A new partnership hosted by WHO, the Health Metrics Network, was created in the biennium. It seeks to increase the availability and use of timely, reliable health information by catalysing the funding and development of core health information systems in developing countries. The International Clinical Trials Registry Platform, bringing together registers of clinical trials worldwide into a global network and establishing a set of international standards for registers to follow, was also launched in 2005.

27. Intensified cooperation with the Global Harmonization Task Force for international harmonization in the regulation of medical devices has enhanced public access to post-market surveillance information, leading to improved patient safety. New WHO biological norms and standards were produced and promoted for blood products, related biological substances and in vitro diagnostic procedures.

28. In order to address issues of concern in cell, tissue and organ transplantation from a global standpoint, a global network of stakeholders was created, the first global guidance documents, which included guidance on xenotransplantation were developed, and a Global Knowledge Base on Transplantation was initiated. WHO prequalification of suppliers and products for treating HIV/AIDS, tuberculosis and malaria became a major global programme. The list of prequalified products is used by United Nations organizations, the Global Fund to fight AIDS, Tuberculosis and Malaria and the World Bank to guide procurement decisions, and is increasingly used by Member States, national treatment programmes and nongovernmental organizations. The programme has been expanded to cover prequalification of active pharmaceutical ingredients and quality control laboratories.

29. Direct support activities including technical assistance and advice on intellectual property rights and trade agreements were provided to countries. WHO continued its collaboration with WTO and initiated an ongoing collaborative effort between UNICEF, UNDP, UNAIDS and the Global Fund to ensure coherence in activities and training relating to intellectual property rights and medicines procurement. WHO also supported participation in regional meetings and training workshops on these topics organized in Africa and Latin America by WTO.

Focusing on results-based management

30. The biennium was marked by renewed efforts to increase WHO's efficiency and effectiveness in support of programme delivery and improving health outcomes. A major achievement was the strengthening of WHO's results-based management framework, including crucial work on the Eleventh General Programme of Work and the preparation for a medium-term strategic plan. This has resulted in improved operational planning, better performance monitoring and increased focus on results.

31. The management of financial resources was improved through regular monitoring and reporting of the resource situation across the Organization, with an emphasis on increased transparency, and by increased engagement internally with all technical programmes and externally with partners to ensure better alignment of resources with the programme budget.

32. Progress was made in implementing the ambitious human resources reforms, including the adoption and internalization of a Global Competency Model for all staff, the establishment of a Staff Development Fund and the roll-out of a leadership programme for all senior managers.

33. Ensuring greater and more efficient response to country needs was a priority during the biennium: all WHO country offices in the African Region, for example, are now linked to WHO's

Global Private Network and the number of country cooperation strategies has reached 130. Underpinning many of the reforms being undertaken is the implementation of the global management system; this Organization-wide endeavour has gained momentum following the selection of the software and system integrators.

Constraints and challenges

34. Although much has been achieved – more indeed, in some areas than initially planned – a number of constraints hindered implementation and limited achievements in terms of improving health outcomes. Weak health systems in many countries, including gaps in current systems for management and supply of medicines and diagnostics, poor laboratory infrastructure and limited human resource capacity at all levels continued to impede progress in improving health conditions in many places. Central to these constraints was the overall lack of consensus among the various stakeholders about the most appropriate strategies for strengthening health systems; countries' limited capacity to strengthen their health systems; and the limited technical and financial support provided to them for these activities.

35. Some aspects of the sexual and reproductive health agenda necessitated extended planning, consensus-building and methodological adaptation of proposed approaches, all of which extended the timeframe for activities.

36. Although significant progress was made during the biennium, challenges remain for the Secretariat in working across programmes and country and regional offices and headquarters. In order to achieve the required results, human resource planning needs to be improved to ensure that the right people with the right skills are in the right place. In some areas there is limited technical expertise at regional or country levels. The quality and level of competencies of WHO staff remains uneven and requires greater attention. Despite improvements in the speed and manner in which the Organization was able to respond to emergencies such as the tsunamis in south-east Asia or the earthquake in south Asia, administrative processes that are sometimes cumbersome and bureaucratic slow down operations. Learning needs to be better integrated into processes in order to improve work methods. Further efforts are required to use resources more efficiently and effectively in line with the results as outlined in the programme budget.

37. One important challenge in the Secretariat's reform efforts is posed by the tight linkages between some of the reform elements. Delays in implementing the mobility and rotation policy, for instance, are attributable to pending improvements in human resource planning across the Organization. Some of the planned reforms in WHO are linked to broader reforms in the United Nations system, globally and at local level. Some specific areas of focus for WHO over the biennium 2006-2007 will include strengthening human resource performance management; further improving resource coordination, (e.g., mobilization and management of voluntary contributions across the Organization); engaging more proactively with key partners; implementing plans to strengthen WHO's capacity at country level; strengthening internal communication; and ensuring the successful roll-out of the global management system.

SUMMARY OF FINANCIAL PERFORMANCE 2004-2005

38. Total expenditure in 2004-2005 was US$ 2729 million, being 33% higher than in 2002-2003 and 97% of the approved budget.

Table 1: Total expenditures
(US$ millions)

REGULAR BUDGET

	2002-2003	%	2004-2005	%
COUNTRIES	318	38	330	38
REGIONS	235	28	234	27
GLOBAL	277	34	307	35
TOTAL	**830**	100	**871**	100

OTHER SOURCES

	2002-2003	%	2004-2005	%
COUNTRIES	369	25	731	34
REGIONS	374	25	585	27
GLOBAL	744	50	845	39
TOTAL	**1 487**	100	**2 161**	100

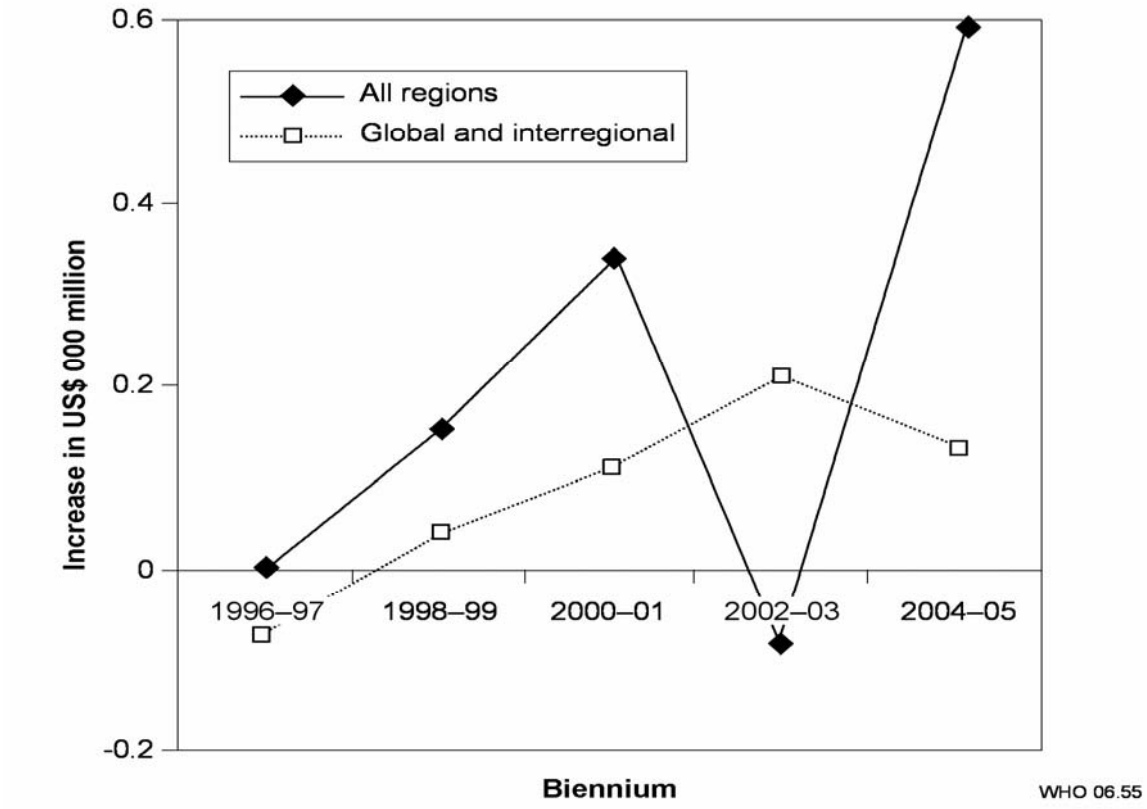
ALL SOURCES

	2002-2003	%	2004-2005	%
COUNTRIES	687	30	1 061	35
REGIONS	609	26	819	27
GLOBAL	1 021	44	1 152	38
TOTAL[1]	**2 317**	100	**3 032**	100
Less eliminations	**267**		**303**	
TOTAL after eliminations	**2 050**		**2 729**	

39. The biennium 2004-2005 represented a shift in emphasis of the Organization's work towards countries and regions. Chart 1 shows the marked shift in expenditures for regions and headquarters in 2004-2005 relative to 2002-2003. For the first time, the trend of steep increases at headquarters was broken, bringing attainment of the goal of a 70-30 resource distribution between countries/regions and headquarters much closer.

[1] Funds were transferred from the regular budget to the Information Technology Fund, the Security Fund and the Real Estate Fund and from the Special Account for Servicing Costs into the Information Technology Fund and the Security Fund. The amounts transferred are treated as expenditure under the regular budget and the Special Account for Servicing Costs. The amounts transferred are treated as income in the Information Technology Fund, the Security Fund and the Real Estate Fund, and eventually as expenditure in line with the activities undertaken within those areas. This accounting treatment is necessary to maintain the integrity of the individual funds while it does lead to duplication of expenditure under the total column.

Chart 1. Increase in expenditures compared to previous biennium for "All regions" and "Global and interregional" activities



40. Overall expenditures were about 97% of the approved total for the programme budget. However, as can be seen from Table 2, the overall figure conceals considerable variances between areas of work. Nine of the 35 substantive areas of work expended 75% or less of their approved budget. In most cases this was attributable to inflexibility in the Organization's financing, making it difficult to direct funding to areas of greatest needs. For the same reason variances also occurred within each area of work.

Table 2: Budget and expenditure summary by area of work - all offices
Financial period 2004-2005

Area of work	**Total** (in thousands US$)		
	Programme budget	**Expenditure**	**%**
Communicable disease surveillance	94 600	100 961	107
Communicable disease prevention, eradication and control	134 286	100 769	75
Research and product development for communicable diseases	114 468	74 186	65
Malaria	126 140	156 669	124
Tuberculosis	124 531	152 492	123
Surveillance, prevention and management of noncommunicable diseases	37 480	41 355	110
Tobacco	20 483	17 715	87
Health promotion	48 164	39 933	83
Injuries and disabilities	17 633	13 227	75
Mental health and substance abuse	23 856	20 675	87
Child and adolescent health	67 349	54 032	80
Research and programme development in reproductive health	67 070	62 299	93
Making pregnancy safer	38 711	22 873	59
Women's health	15 094	8 583	57
HIV/AIDS	218 116	126 106	58
Sustainable development	28 840	31 008	108
Nutrition	20 526	17 407	85
Health and environment	86 946	77 625	89
Food safety	22 453	14 059	63
Emergency preparedness and response	119 037	247 375	208
Essential medicines: access, quality and rational use	51 447	49 956	97
Immunization and vaccine development	437 146	688 255	157
Blood safety and clinical technology	24 635	22 228	90
Evidence for health policy	80 606	59 167	73
Health information management and dissemination	46 162	49 302	107
Research policy and promotion	20 217	13 943	69
Organization of health services	159 966	145 935	91
Governing bodies	27 791	28 362	102
Resource mobilization, and external cooperation and partnerships	38 264	28 736	75
Programme planning, monitoring and evaluation	11 326	10 431	92
Human resources development	34 912	37 881	109
Budget and financial management	43 841	43 659	100
Infrastructure and informatics services	174 715	190 147	109
Director-General, Regional Directors and independent functions	28 670	35 613	124
WHO's presence in countries	148 630	161 434	109
Substantive areas of work - total	**2 754 111**	**2 944 397**	
Miscellaneous			
Exchange rate hedging	20 000	14 550	

Area of work	Total (in thousands US$) Programme budget	Expenditure	%
Real Estate Fund	6 000	11 851 [1]	
Information Technology Fund	35 000	41 943 [1]	
Security Fund	9 000	19 215 [1]	
Miscellaneous – total	**70 000**	**87 559**	
Total - ALL OFFICES	**2 824 111**	**3 031 956**	
Plus UNFPA Programme Support Costs		79	
Less eliminations		303 365	
Total WHO Programme Activities	**2 824 111**	**2 728 670**	**97**

Financing

41. Seventy per cent of expenditure was financed from voluntary contributions of US$ 2100 million (a 61% increase compared to 2002-2003) and the balance from assessed contributions, miscellaneous income, interest income, and carried-forward amounts from the last biennium. Regular budget income in 2004-2005 was US$ 860 million of which US$ 803 million was received in the biennium (US$ 781 million assessments and US$ 22 million miscellaneous income). Internal borrowings and working capital draw-downs, which finance non-collected assessments, totalled US$ 44 million at 31 December 2005.

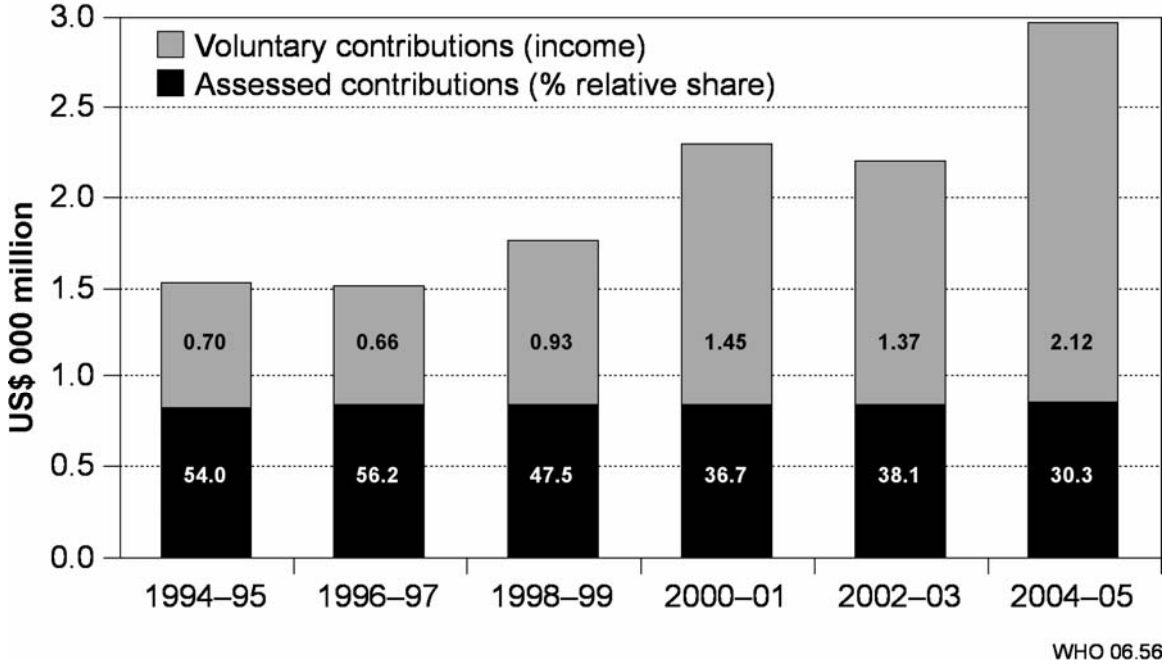
Table 3: Total Income
(US$ millions)

	2002-2003	2004-2005	% change
Regular budget	856	860	1%
Other sources	1 320	2 124	61%
Total	**2 176**	**2 984**	**37%**

42. The proportion of overall financing from voluntary contributions reached approximately 70%, compared to approximately 60% in 2002-2003; of this, two thirds was received from 10 Member States. The 12-year trend illustrated in Chart 2, shows that WHO has gradually changed from being predominantly financed from regular budget sources to becoming predominantly financed from voluntary resources.

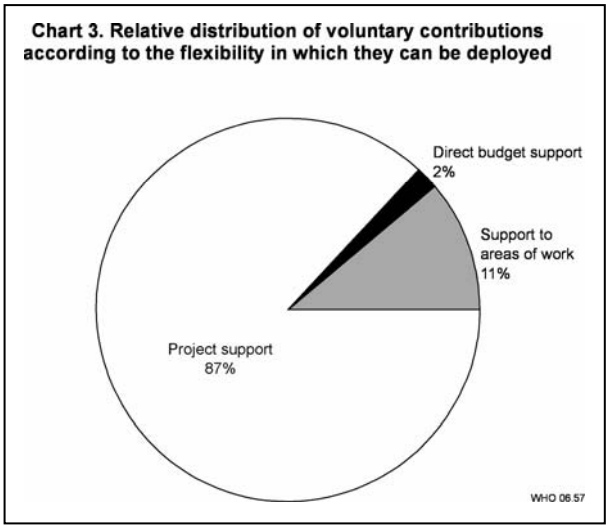
[1] Funds were transferred from the regular budget to the Information Technology Fund, the Security Fund and the Real Estate Fund and from the Special Account for Servicing Costs into the Information Technology Fund and the Security Fund. The amounts transferred are treated as expenditure under the regular budget and the Special Account for Servicing Costs. The amounts transferred are treated as income in the Information Technology Fund, the Security Fund and the Real Estate Fund, and eventually as expenditure in line with the activities undertaken within those areas. This accounting treatment is necessary to maintain the integrity of the individual funds while it does lead to duplication of expenditure under the total column.

Chart 2. Development of voluntary contributions and regular budget over the past ten years



43. This shift has provided an overall increase in resources and allowed the Organization to expand its scope and scale of operation to meet needs of Member States and demands from development partners. However, it has also posed some challenges, since most voluntary contributions come with varying degrees of restrictions attached. The most flexible contributions are core voluntary contributions made available to the Organization with no restrictions attached, which constituted only 2% of the total voluntary contributions. The next flexible type are voluntary contributions made available to the Organization at the level of areas of work, which constituted about 11%. The least flexible are voluntary contributions earmarked for specific projects or activities within approved workplans, which constituted the remaining 87% (see Chart 3).

Chart 3. Relative distribution of voluntary contributions according to the flexibility in which they can be deployed



44. The income profile depicted in Chart 3 was recorded under 4297 contribution lines for the Voluntary Fund for Health Promotion, and some 1500 separate financial reports were prepared for contributors. To honour the agreements and provide the financial reporting, WHO operated an elaborate system of 9349 allotments to keep money from different sources and for different purposes separate, which required considerable administrative resources to manage. It also had an adverse effect on technical performance, as implementation of activities often depended on whether, and when, there were sufficient resources available. Even though overall, the Programme budget appeared to be fully financed, several areas of work remained

underfunded, with financing tied to specific parts of the work plans, or arriving too late in the biennium to achieve the results as expected.

45. A challenge in the coming years will be to maintain and possibly further increase the level of income, while working with contributors to make their funding more flexible, thereby providing more effective support for implementation of the programme budget and the coming medium-term strategic plan. The Performance assessment report at hand is, as part of WHO's results-based management and accountability framework, an important component towards achieving greater effectiveness in the financing of the Organization.

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