WORLD HEALTH ORGANIZATION

PROGRAMME, BUDGET AND ADMINISTRATION
COMMITTEE OF THE EXECUTIVE BOARD
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Progress in implementing the 2004-2005 programme budget

1. Implementation of the Programme budget 2004-2005 was systematically monitored up to 31 December 2004 at all WHO offices by means of a revised mid-term review process, as part of the biennial monitoring and evaluation cycle.

2. The revised mid-term review, which supplements regular and periodic workplan monitoring, is used to assess the progress made by each WHO office towards achievement both of its specific expected results and of the Organization-wide expected results appearing in the programme budget. The review uses a "traffic light" coding system whose three colours indicate the following: that good progress towards achievement of the expected result in question is being made and that this is not thought likely to be significantly affected by impediments and risks; that progress towards achievement of the expected results is considered to be under threat, with action required to overcome the effects of delays, impediments or risks; or that there is a real danger that the expected result will not be achieved, owing to impediments or risks considered likely to have a significant impact on progress. Textual information on impediments and risks together with actions required to improve progress during the remainder of the biennium is also provided in the review.

3. Evidence for the colour ratings derives from the review of the status of delivery of products and services for each office's expected results as of 31 December 2004; consideration of impediments and risks affecting, or expected to affect, implementation; and findings of technical reviews, and programmatic and thematic evaluations, where available.

4. Colour ratings for individual offices deriving from the mid-term review were consolidated and findings aggregated in relation to the relevant Organization-wide expected result shown in the Programme budget 2004-2005. A brief overview of progress towards the achievement of Organization-wide expected results is given below for the period covered by the review;[1] details are given by area of work.

5. Progress on **communicable disease surveillance** was slowed by the process of revising and adopting the International Health Regulations. Work on data collection from the 46 countries of the WHO African Region proved difficult to perform and in the Western Pacific Region, where three major outbreaks of infection had to be managed, some resources for capacity building were redirected for emergency response activities.

[1] An initial draft, in English, presenting a summary of key findings of the mid-term review is available upon request.

6. Work on **communicable disease prevention, eradication and control** was largely on track. The area of work was concentrating on the development of an evidence-based strategy for using combined interventions for the control of neglected diseases, and on fostering greater collaboration between different international control initiatives in support of disease-specific interventions. Work also continued in support of the prevention, control and eradication or elimination of specific diseases. However, the security conditions prevailing in some countries hindered progress. Programme implementation was also affected by funding constraints. In the South-East Asia Region, cross-border collaboration required strengthening in order to achieve targets for the eradication or elimination of specific communicable diseases.

7. In the area of **research and product development for communicable diseases** progress was largely on track and all but one of the targets set for the biennium were expected to be met or exceeded. The following achievements were noted: the establishment of the genetic basis for variation and clinical presentations in *Leishmania* infections; the undertaking of studies on the effect of health-sector reform policies on tropical disease control; the regulatory approval of a six-dose treatment regimen of artemether-lumefantrine for children; the gathering of evidence of effectiveness of artemisinin-based combination therapy in malaria control; and the production of research guidelines and tools that were then made accessible to research and control programmes. Funding constraints were, however, likely to have an adverse affect on the area of work's ability to meet longer-term targets that depend on established milestones being attained and sustained support being provided over several bienniums. If this occurs it will lead to fewer outputs in the future and it will take longer to generate the knowledge, tools and research capacity that are required to meet the global targets for controlling communicable disease, including the health-related Millennium Development Goals.

8. Progress in the fight against **malaria** was considered to be on track at the midpoint of the biennium and 23 countries that are endemic for the disease had adopted antimalarial treatment policies with artemisinin-based combination therapies; 14 countries had adopted intermittent preventive treatment as a protection for pregnant women; an additional five countries were already implementing the treatment. Countries had benefited from increased resources through the Global Fund to Fight AIDS, Tuberculosis and Malaria; malaria was on the agendas of the G8 Summit (scheduled to be held in Gleneagles, United Kingdom, in July 2005), the Fifty-eighth World Health Assembly, and the Fourth African Union Summit (Abuja, 24-31 January 2005); increased advocacy by Roll Back Malaria partners had also encouraged the staging of high-profile global events, while improving media coverage. However, the African, South-East Asia and Eastern Mediterranean regions reported delays in product delivery due to financial constraints.

9. Work to control **tuberculosis** was progressing well and, in the majority of the cases, efforts to meet Organization-wide expected results were on track. One hundred and eighty-two countries were reporting results to WHO in relation to the strategy of directly observed treatment, short-course (DOTS). Globally, reductions in both the prevalence of tuberculosis and the number of deaths it causes were on track to meet the targets for 2015 set out in the Millennium Development Goals. The latest data showed that progress was also being made towards achieving the targets for case detection and treatment success that were reset for 2005 by the Amsterdam Declaration to Stop Tuberculosis (2000), subsequently endorsed by the Health Assembly in resolution WHA53.1. The Stop TB Partnership, hosted by WHO, had some 350 partners at the time of the review, and its Global TB Drug Facility provided 1.7 million treatments in 2004. The greatest challenge for tuberculosis control lay in the African Region where the numbers both of cases of tuberculosis and of deaths from the disease were being driven by the HIV/AIDS epidemic. Global incidence of tuberculosis was still rising at 1% per year owing to the trend in Africa. In view of this situation, core elements of the DOTS strategy and joint tuberculosis/HIV interventions should be strengthened, health systems improved and serious efforts made to tackle the crisis in the health workforce. In the

European Region, the review indicated that the greatest challenges were posed by the slow expansion of DOTS coverage as well as the special burden of multidrug-resistant tuberculosis. The current reporting systems represented a further hurdle to progress as they impede DOTS monitoring and evaluation. In the South-East Asia Region, clear progress was being made in expanding DOTS programmes, especially in the Region's two largest countries. However, such progress was at risk in the countries struck by the south-Asian earthquakes and tsunami of 26 December 2004. In this Region, as well as in the Region of the Americas and the Eastern Mediterranean and Western Pacific regions, priorities included reaching those not yet served by DOTS by involving new public and private providers, engaging communities and promoting an international standard of tuberculosis care. In addition, capacity for tuberculosis surveillance, and interventions to address HIV-related tuberculosis and drug resistance needed to be strengthened everywhere.

10. In the area of **surveillance, prevention and management of noncommunicable diseases**, it was feared that certain expected results would not be achieved. In the Region of the Americas and the African and Eastern Mediterranean regions, discussions on the elaboration of strategies for the prevention of noncommunicable diseases had still to be concluded and agreement had not yet been reached on implementation processes. The Region of the Americas had implemented an integrated approach to chronic disease prevention in several countries, but progress was not being made as rapidly as had been foreseen. In the African Region, the noncommunicable disease expert committee needed to be given sufficient authority to perform its role and improved funding was required to accelerate progress towards the establishment of national integrated programmes for prevention and control. The development of practical guidance for national programmes for chronic, noncommunicable diseases was also still under discussion.

11. The review considered that efforts to ensure that governments, international agencies and other partners were equipped to implement approaches to **tobacco** control were on track. Forty-nine countries had ratified the WHO Framework Convention on Tobacco Control and 33 Member States were deemed to have met the criteria for comprehensive tobacco-control policies and national plans of action. One hundred and thirty-eight Member States had completed the Global Youth Tobacco Survey; a further 27 Member States had repeated the Survey. A global health professional survey had also been initiated together with new projects under the umbrella of the United Nations Ad Hoc Inter-Agency Task Force on Tobacco Control; tobacco-control strategies were also being integrated into the Organization's other core areas of work, such as Women's health. Reports from WHO regions indicated that commitment on the part of national authorities was essential to ensure further progress. It was noted that financial constraints had affected the progress of some activities in the Region of the Americas and the African and European regions.

12. Good overall progress was reported in **health promotion.** Health promotion capacity was being mapped in all regional offices and intercountry meetings on capacity building and the development of a framework for health promotion had been held in the WHO South-East Asia and Eastern Mediterranean regions. Strong advocacy was being provided for health promotion in all regions in preparation for the Sixth Global Conference on Health Promotion (scheduled to be held in Bangkok from 7 to 11 August 2005).

13. Efforts are being made to equip governments and their partners so that they can formulate and implement cost-effective, gender-specific strategies to prevent and mitigate the consequences of violence and unintentional **injuries and disabilities;** this work was reported to be progressing well. In the South-East Asia Region, however, it was considered unlikely that Organization-wide expected results related to capacity building in high-priority countries would be fully achieved as the rate of progress varied widely across countries. In the case of the Western Pacific Region, extrabudgetary funds were required for road safety activities.

14. It was reported that good progress was being made in work on **mental health** and **substance abuse,** including normative work and effective country cooperation. Important advances had been made in the area of mental health legislation and human rights in the Region of the Americas and the European Region. In the Region of the Americas, several countries were revising their relevant legislation, and introduction of a human rights perspective was proving an effective tool for the improvement of mental health care. Work to implement national mental health policies and plans, and develop plans on mental health and disasters had also enjoyed considerable success. Financial constraints, however, had hindered the preparation of training packages on depression. In the European Region, Ministers of Health at the WHO European Ministerial Conference on Mental Health (Helsinki, January 2005) committed themselves to the Mental Health Declaration for Europe, endorsing a plan of action with specific milestones. The Global Campaign Against Epilepsy: out of the shadows, was successfully implemented in the African Region as well as in China, and suicide prevention activities were developed in the European and Western Pacific regions. Additional resources were required to deal with the increased demand for production of instruments, guidelines and training packages for the various mental, neurological and substance abuse disorders that fall within this area of work. In the South-East Asia Region it was noted that community mental health initiatives were being afforded greater priority, thus removing an impediment to progress in this area. In the Western Pacific Region, the following impediments were noted: a lack of culturally appropriate advocacy materials; insufficient collaboration between mental health and public education experts; difficulties in attracting young health professionals to the field of mental health; and country-level funding constraints for activities in relation to the harmful use of alcohol.

15. Despite overall progress in the area of **child and adolescent health**, there was a danger that several expected results would not be achieved in one or more WHO regions. In the African and European regions, funding constraints were seen as an obstacle to the provision of technical and policy support to give effect to health-related articles of the Convention on the Rights of the Child; and research, technical and policy support initiatives for strategies, policies, norms and standards to protect adolescents from disease and behaviours and conditions that put health at risk. Financial constraints were also reported to be hampering activities at headquarters. In the South-East Asia Region, where nine of the 11 Member States have adapted the strategy for integrated management of childhood illness,[1] more focused attention was reportedly needed to promote pre-service training in the strategy. Member States also required support to elaborate strategies and interventions to promote neonatal health and survival. In the Region of the Americas, plans were in place to improve child survival by incorporating management of neonatal illness into national plans for the integrated management of childhood illness. However, financial constraints continued to hamper progess.

16. Lack of funding was reported to be adversely affecting work to achieve certain expected results for **research and programme development in reproductive health**, especially at headquarters and in the African and European regions. The Organization's role in a strategy for reproductive health (endorsed by the Health Assembly in resolution WHA57.12) was seen as instrumental in supporting countries to develop national programmes for reproductive health. In addition, WHO/UNFPA strategic partnership programme had facilitated the adaptation and adoption by countries of evidence-based standards for family planning and the control of sexually transmitted infections.

17. The provision of policy and technical support in connection with national plans of action for **making pregnancy safer** was judged to be on track in all WHO regions. Similarly, work on adapting and introducing evidence-based guidelines for maternal and newborn care, family planning and post-

[1] See resolution WHA48.12.

abortion care was progressing satisfactorily. However, there was a risk that work to strengthen health service management and interventions to ensure the availability of maternal and newborn health services and information would not be achieved; funding constraints were cited as an impediment to progress in this area, especially in the African and Eastern Mediterranean regions. In the Region of the Americas, the reduction of maternal mortality was slow and funding constraints were cited as an impediment to work on improving the quality of health services in Latin America and the Caribbean.

18. Efforts on behalf of **women's health** showed steady progress throughout the Organization; activities concerned included capacity building together with the development of tools and guidelines. At headquarters, the first report following a multicountry study on violence against women was being finalized. The programme was working towards a clearer mandate, direction and measures to make gender an institutional concern for the entire Organization. With these aims in mind, a global strategy and plan of action were being drawn up. In order to guide improvements in WHO's work, a study had been commissioned and the resulting report formed a basis for revised strategic directions for this area of work. Globally, work on reducing gender-based inequalities in health continued. Efforts in this area were severely hampered by limited resources, both financial and technical; this was particularly true for the majority of the regional offices and a systematic review of the entire area of work was being planned in collaboration with the regional offices.

19. Good progress was being made in relation to the provision of support for the implementation, integration and intensification of essential health-sector interventions against **HIV/AIDS**. Thirty-one teams were fielded to help expand access to antiretroviral treatment and strengthen prevention programmes, and a task force on tuberculosis/HIV coinfections was established to support integration of antiretroviral treatment into national tuberculosis programmes in several countries. In the Region of the Americas, significant progress was achieved in meeting the regional goal agreed by Heads of State at the Special Summit of the Americas (Monterrey, Mexico, January 2004). The Special Summit Declaration made a commitment to universal coverage with antiretroviral treatment as soon as possible, with at least 600,000 people under treatment by 2005; at the mid point of the biennium 590,000 people were already benefiting from the treatment. Nonetheless, substantial inequities in access to treatment existed among countries in the Region. In the African Region, certain activities were being affected by lack of funding. In the Eastern Mediterranean Region, the provision and integration into health-care delivery systems of prevention and care packages for HIV/AIDS and sexually transmitted diseases were reported to be progressing more slowly than had been foreseen.

20. In the area of **sustainable development,** preparation of the health components of poverty reduction strategy papers was advancing well in several countries. A publication on health, human rights and poverty reduction strategies had also been prepared; this will be revised following widespread consultation during 2006. Training workshops and work programmes in the area of trade and health had been supported; model public-health legislation had been developed, incorporating priorities expressed in the Millennium Development Goals; and trade and health intelligence was systematically gathered and made available on the web, as were the texts of national and international health legislation. Progress had also been made on interorganizational collaboration and the development of good practices concerning health gains and dissemination of lessons learnt. Meetings of the High Level Forum on the Health Millennium Development Goals were organized during the period under review and some 40 countries were taking steps to translate the findings of the Commission on Macroeconomics and Health into national policy. Despite this progress, limited resources and uncertainty about future funding were having an affect throughout this area of work. Consequently, there was a risk that various expected results would not be achieved.

21. Progress was reported for work on **nutrition**; however, in the African Region better mobilization of partners was required to improve nutritional surveillance and conditions did not allow

for full implementation of technical support activities. In the Western Pacific Region activities to promote the adoption and implementation of national infant and young child feeding and food fortification in the South Pacific were being hindered by financial constraints. In response to the funding difficulties reported by regional offices, efforts were being made to increase the support they received.

22. Despite good progress in the area of **health and environment,** some expected results were taking longer to achieve than planned. In the South-East Asia Region, it was possible that the delays encountered in improving preparedness and response to chemical and radiological incidents, and to other emergencies, were largely attributable to the need to broaden partnerships beyond ministries of health and focus on capacity building at the country level. In both the African and South-East Asia regions, it was considered that there was a danger that results related to occupational and environmental health would not be achieved owing to financial constraints; it was felt that such obstacles posed a particular problem in Africa, where intersectoral coordination was considered inadequate. At headquarters, delivery of products for expected results was largely on track, with some delays being reported in relation to chemical safety. In the Eastern Mediterranean Region, implementation of activities related to the production of good practice tools and guidelines was also behind schedule.

23. With regard to **food safety,** it was considered that each of the Organization-wide expected results of relevance to the African Region was at risk of not being achieved; the expected results for capacity building in the area of risk communication and food safety education were felt to be in the greatest danger, owing to lack of funding. Funding constraints had also affected product delivery in the South-East Asia and European regions. In the Eastern Mediterranean Region, operational and security constraints had reportedly affected product delivery, especially in Afghanistan and Pakistan. In the Region of the Americas, significant progress was reported in surveillance, disseminating technical reports on microbiological risk assessment, and participation in meetings of the Codex Alimentarius Commission. Funding constraints had limited the Region's capacity-building efforts, which were needed for the implementation of a global strategy for the surveillance of foodborne diseases.[1] Significant budgetary constraints at headquarters meant that targets in relation to the scientific advice needed for global normative work, including risk assessments needed for the Codex Alimentarius Commission, had not been achieved.

24. Good progress was reported in the area of **emergency preparedness and response.** The three-year programme for enhancing WHO's performance in crises, involving country and regional offices and headquarters, was launched in order to improve WHO's contribution to crisis-affected Member States and make it more predictable. The Organization's mechanisms for response were also strengthened at field level through a joint regional and headquarters initiative. These changes provided the foundation for WHO's rapid and effective response to the south Asian earthquakes and tsunami of 26 December 2004. Health action was now an integral part of all interagency Consolidated Appeals. WHO was also making an ever-increasing contribution to interagency activities and forums. In the African Region, although good progress had been made, dealing with emergencies had led to a diversion of efforts; it was anticipated that, as a result, certain expected results would not be fully achieved. In the South-East Asia Region it was reported that in some countries emergency health information systems either still needed to be established or required strengthening; further work on in-country assessments and promotion of collaboration with donor agencies was also needed. In the Western Pacific Region, where progress was also rated favourably, it was considered that the

[1] See resolution WHA53.15.

following were required in order to improve progress: the review and further development of national disaster management plans in various countries; the further strengthening of interagency activities to improve disaster response coordination; and studies on policies and procedures for health emergency management.

25. Steady progress was reported in framing and implementing national drug policies and monitoring their impact; this was also true for efforts to increase equitable access to **essential medicines** while ensuring quality, safety and efficacy. Nevertheless, about one third of the world's population still lacked access to essential medicines and about half of the patients receiving medicines were failing to take them correctly – a situation that has serious consequences for health and economies. In addition, few Member States regularly monitored the use of medicines nationally or implemented all the recommended core components for promoting the rational use of medicines. Furthermore, policy formulation in relation to financing the supply and increasing the affordability of essential medicines continued to be hindered by the negative influence of certain powerful stakeholders, and knowledge about how to improve use of medicines for chronic conditions (including diabetes, hypertension, epilepsy and mental health problems) was still lacking, particularly in resource-poor settings.

26. In the majority of cases, work to achieve expected results in support of **immunization and vaccine development** was considered to be on track across the Organization. The re-emergence of wild-type poliovirus transmission in several African countries, however, represented a serious setback for global eradication efforts. As part of efforts to achieve a sustainable reduction in measles mortality and interrupt transmission, eight priority countries had begun implementation of the WHO/UNICEF comprehensive strategy for sustainable measles mortality reduction and another 44 were expected to implement the strategy in 2005. International reference materials and guidelines for development of vaccines against dengue haemorrhagic fever were also completed during the period under review. Guidelines for the production and control of vaccines were either developed or revised, and standards, molecular methods for quality control and regional reference materials were generated as anticipated. Regulatory research was initiated for vaccines against BCG, rotavirus, rabies, Japanese encephalitis and human papillomovirus, as well as for DNA vaccines. In the African Region, effective vaccine store management assessment and vaccine management training needed to be expanded and additional funds were required for training activities related to yellow fever and for the elimination of maternal and neonatal tetanus. In the European Region, good progress was reported although additional country-level funding was required to support the introduction of new vaccines in some countries, particularly the vaccine against hepatitis B. Further resources were also needed for strengthening routine immunization and surveillance for measles, rubella and congenital rubella syndrome, for surveillance and campaigns in respect of poliomyelitis, measles and rubella, and for cold-chain logistics in certain countries. In the Eastern Mediterranean Region, seven countries had failed to meet goals relating to coverage with three doses of diphtheria-tetanus-pertussis vaccine and BCG vaccine against tuberculosis, owing in part to the prevailing security situation. In the Western Pacific Region, coverage of activities to improve immunization safety needed to be extended and additional funds were required to achieve the measles elimination goals.

27. Progress was reported across the area of **blood safety and clinical technology**; this was particularly the case for the provision to selected countries of support for securing blood safety; for normative work on the quality of diagnostics tests for hepatitis B and C and HIV infection; and on the role of policy formulation and issues relating to quality, use and access with regard to the application of information and communication technologies to improve health-care delivery. Despite this, there was a risk that some expected results in this area of work would not be achieved. At headquarters and in the African Region, financial and human resource constraints were reported to be delaying the delivery of various products, including global normative function; they were also reported to be

affecting implementation of resolution WHA57.18 on human organ and tissue transplantation. In the Eastern Mediterranean Region, several countries reported that provision of models and advice was not adequate for work on establishing systems to improve access to and use of the following: transfusion therapy, injections, diagnostic imaging, laboratory services, medical devices and procedures. The appointment in 2005 of a staff member in the Regional Office to focus exclusively on this area was expected to improve the situation. In the Region of the Americas and the European Region, efforts to improve access to safe blood and clinical technologies were largely contingent upon government commitments and the availability of resources at country level. Regional activities in the Americas had to be significantly cut back when a substantial source of extrabudgetary funding came to an end.

28. All but one of the Organization-wide expected results for **evidence for health policy** were judged to be on track for achievement. In the Western Pacific Region, there was a recognized need to improve the link between information and evidence and policy formulation and health programming; for this reason, it was considered that the expected result related to availability of an evidence base to guide policy recommendations was at risk of not being fully achieved.

29. A knowledge management strategy to guide work on **health information management and dissemination** was being elaborated in close consultation with external stakeholders. The Ministerial Summit on Health Research (Mexico City, November 2004) provided further impetus to efforts and encouraged contacts with key external audiences such as researchers, practitioners, donors and other partners. Libraries at all levels of the Organization continued to deliver services, within the limits of available resources. In addition, the *Bulletin of the World Health Organization* continued to be published monthly, in both electronic and print formats; free access was provided to biomedical journals for health institutions in developing countries; an eHealth unit was created in order to guide the application of electronic information communication technology in health systems; a new unit on knowledge communities and strategies was established to help WHO and health systems to make better use of experiential knowledge; and WHO Press was established towards the end of 2004 in order to strengthen the publications enterprise and publications policies at all levels of the Organization. In addition, a multilingual platform was created on the Internet and obtained support at country level, although additional efforts and resources would be needed at regional level.

30. In the area of **research policy and promotion,** research policy was updated. Furthermore, the Mexico Statement on Health Research, agreed at the Ministerial Summit on Health Research (Mexico City, November 2004) called for research partnerships and networks to be strengthened. The initiative on health research systems analysis was also launched in the wake of pilot studies that were nearing completion in 13 low- and middle-income countries. In the African Region, efforts continued to ensure that national ethics review committees were in place and functional; it was noted that training in research ethics would be critical for their success. Work was also required to strengthen national health research systems.

31. Progress was being achieved in realizing the expected results for the **organization of health services.** In the South-East Asia Region, although good progress had been made, human resource plans were not yet in place in all countries, and the review of national capacity needed to be accelerated. In the European Region, it was reported that several expected results were at risk of not being achieved owing to the great demand for services coupled with funding constraints at country level. Similarly, in the Eastern Mediterranean Region, there was an urgent need for national human resource development policies and plans to be elaborated; these should include the fields of nursing and midwifery.

32. Support to regional and global **governing bodies** in the form of efficient preparation and conduct of sessions, including timely dissemination of documentation and post-session records and resolutions for policy-making, was generally seen to be progressing well. Full achievement of some expected results in the African Region and at headquarters, however, was at risk owing to funding constraints.

33. In the area of **resource mobilization, and external cooperation and partnerships** good progress was reported in expanding partnerships and strengthening collaboration both within and outside the United Nations system. The United Nations General Assembly at its fifty-ninth session, for example, adopted various resolutions of direct concern to WHO. During the period under review, WHO also increasingly assumed a leadership role in working groups of the United Nations Development Group, particularly for coordination and streamlining of development efforts within the context of the United Nations resident coordinator system. A significant increase in extrabudgetary support was achieved in 2004 through fundraising activities and the streamlining of relations with major foundations improved both levels and predictability of funding. However, activities to coordinate relations with the private sector continued to be restricted as a result of human and financial resource constraints. It was reported that, in the Western Pacific Region, better communication and coordination with existing and potential donors was needed and that in the South-East Asia Region the resource mobilization capacity of regional and country offices needed to be strengthened if extrabudgetary targets were to be achieved.

34. It was considered that four expected results for **programme planning, monitoring and evaluation** were in danger of not being fully achieved at headquarters and in at least one of the regions. Work to renew the results-based management framework had progressed well and improvements in the consistency and inclusiveness of strategic planning had been recorded, especially following the introduction of a peer review process. The relationship between strategic and operational planning still needed to be made more coherent, however, and compliance with business rules continued to be inconsistent throughout the Organization, especially where operational planning was concerned. There was still room for improvement in the formulation of expected results, the design of indicators and their application for measuring achievement. It was reported that the development of a quality assurance model was delayed, and that staff remained unfamiliar with results-based management practices, underlining the need for intensified training in 2005. The lack of a common, integrated information technology system to support planning and monitoring across the three levels of the Organization was a major obstacle to ensuring compliance and consistency of planning and monitoring worldwide. In the African Region, it was noted that the evaluation system was not yet firmly in place and that several linked activities had not been implemented.

35. Good progress was reported across the Organization in the area of **human resources development.** A human resources reporting system, a workforce planning tool, internet-based systems to provide information on post descriptions and to assist performance management and development had all been developed and were being piloted; a recruitment strategy was also noted by the Executive Board at its 113th session.[1] A competency framework was put in place and competencies used as a tool for the selection and development of staff and for performance management activities. Nevertheless, despite strict application during selection, it was recognized that further efforts were required in order to satisfy gender and geographical criteria established by governing bodies of the Organization.

[1] See document EB113/2004/REC/2, summary record of the tenth meeting, section 4.

36. Good progress was also reported throughout the Organization in relation to **budget and financial management.** New financial reports were developed during the period under review to improve the information available to managers; investment returns were in line with established benchmarks; systems for inter-office vouchers, personal accounts and country office imprest were put in place and more efficient banking arrangements implemented.

37. All the expected results for **infrastructure and informatics services** were considered to be on course for achievement, with the exception of those relating to the establishment of a communication network and administrative and technical systems linking all WHO offices, and those concerning the provision of efficient support to governing bodies and technical meetings. These were all considered to be at risk of not being fully achieved in at least one of the regions.

38. Efforts of the **Director-General, Regional Directors and independent functions** to direct, support and lead WHO offices were considered to be on course throughout the Organization; no appreciable impediments were identified to hinder achievement of the expected results.

39. **WHO's presence in countries** in support of the delivery of WHO's core functions was generally considered on track in relation to Organization-wide expected results. Further strengthening of the capacity of WHO's country teams was however needed in critical areas, including management, health systems, aid coordination and partnerships. Regional offices and WHO Representatives and Liaison Officers were now exercising full responsibility for formulation and follow-up of country cooperation strategies. Progress in developing the "one country" plan and budget, within the results-based management framework, contributed to giving the framework a better country focus. There had been progress in the elaboration of regional strategies for strengthening WHO's presence, with regional variations in approach and pace; however, more needed to be done for gathering health intelligence in support of country presence. Progress in establishing connectivity between country offices was uneven; priority in this work had been given to the African Region.

40. **Financial implementation –** The interim financial statements include detailed reporting on the financial implementation of the Programme budget for 2004. The financial highlights are as set out below:

FINANCIAL HIGHLIGHTS
(in millions of US dollars)

	2000-2001	*2002-2003*	**2004**		*2000-2001*	*2002-2003*	**2004**
Income				**Expenditure**			
Regular budget	*843*	*856*	**423**	Regular budget	*820*	*830*	**480**
Extrabudgetary resources				Extrabudgetary resources			
Voluntary Fund for Health Promotion	*1 117*	*1 030*	**747**	*Voluntary Fund for Health Promotion*	*945*	*1 017*	**740**
WHO trust funds and United Nations programmes	*411*	*290*	**194**	*WHO trust funds and United Nations programmes*	*335*	*199*	**92**
Total income WHO programme activities	*2 371*	*2 176*	**1 364**	Total expenditure WHO programme activities	*2 100*	*2 046*	**1 312**
Non-WHO programme activities [a/]	*329*	*434*	**227**	*Non-WHO programme activities* [a/]	*400*	*424*	**315**
Total income	*2 700*	*2 610*	**1 591**	**Total expenditure**	*2 500*	*2 470*	**1 627**

[a/] Non-WHO programme activities include trust funds of various programmes and entitities, such as the trust fund for the Joint United Nations Programme on HIV/AIDS (UNAIDS); International Agency for Research on Cancer (IARC); the Global Fund to Fight AIDS, Tuberculosis and Malaria; and the International Computing Centre.

41. Good progress was made in reaching the necessary level of resources to implement the Programme budget 2004-2005 and the average rate of financial implementation for 2004 was 51.6% for the substantive areas of work. Detailed figures are available in the Unaudited interim financial report on the accounts of WHO for 2004.[1] Table 2 of the section on the interim financial implementation of WHO's Programme budget 2004-2005 for the year 2004, attached as an Annex to the present document, shows the level of financial implementation for all offices by area of work. Table 3 provides information at a summary level by office,[2] and Table 4 shows financial implementation for each office by area of work.[3]

42. The Annex to the report gives detailed financial reporting on extrabudgetary income and expenditure.[4] The Voluntary Fund for Health Promotion is the main vehicle through which other sources of income and expenditure are accounted. In 2004, both income and expenditure amounted to US$ 740 million each. The balance brought forward at the overall Fund level is largely the same at the end of the year in comparison with the beginning of the year. This balance represents some seven months coverage of expenditure across all areas of work.

43. The 51.6% overall rate of implementation for all offices conceals a wide degree of variation, from 24.9% for HIV/AIDS to 79.8% for Emergency preparedness and response. There are several factors that underlie this broad range of achievement. First, there is a lack of correlation between income received and resource requirements. In other words, although the level of income may be adequate overall, earmarking of income by donors can lead to over-resourcing in some areas of work and under-resourcing in others. A second factor is the timing of income: a substantial amount of income was received in some areas of work late in the year and thus could not be utilized before the end of 2004.

[1] Document A58/26, page 51.

[2] Ibid., pp. 52 and 53.

[3] Ibid., pp. 55-67.

[4] Document A58/26 Add.1.

ANNEX

BUDGET AND EXPENDITURE SUMMARY BY AREA OF WORK – ALL OFFICES AS AT 31 DECEMBER 2004

(in thousands of US dollars)

Area of work	Regular budget			Other sources			Total		
	Programme budget 2004-2005	Expenditure 2004	%	Programme budget 2004-2005	Expenditure 2004	%	Programme budget 2004-2005	Expenditure 2004	%
Communicable disease surveillance	36 600	18 537		58 000	34 332		94 600	52 869	55.9
Communicable disease prevention, eradication and control	23 786	10 648		110 500	39 554		134 286	50 202	37.4
Research and product development for communicable diseases	3 468	3 002		111 000	31 662		114 468	34 664	30.3
Malaria	17 140	9 301		109 000	49 224		126 140	58 525	46.4
Tuberculosis	12 031	6 686		112 500	56 741		124 531	63 427	50.9
Surveillance, prevention and management of noncommunicable diseases	23 480	12 021		14 000	10 049		37 480	22 070	58.9
Tobacco	9 983	4 896		10 500	4 823		20 483	9 719	47.5
Health promotion	16 664	8 937		31 500	15 949		48 164	24 886	51.7
Injuries and disabilities	5 133	2 675		12 500	4 237		17 633	6 912	39.2
Mental health and substance abuse	14 356	6 409		9 500	4 704		23 856	11 113	46.6
Child and adolescent health	15 849	8 478		51 500	19 852		67 349	28 330	42.1
Research and programme development in reproductive health	9 070	4 022		58 000	30 631		67 070	34 653	51.7
Making pregnancy safer	13 211	6 970		25 500	5 989		38 711	12 959	33.5
Women's health	4 094	2 116		11 000	2 972		15 094	5 088	33.7
HIV/AIDS	18 116	11 483		200 000	42 818		218 116	54 301	24.9
Sustainable development	14 840	8 176		14 000	9 951		28 840	18 127	62.9
Nutrition	9 526	4 651		11 000	5 705		20 526	10 356	50.5
Health and environment	39 946	17 931		47 000	23 729		86 946	41 660	47.9
Food safety	9 453	4 921		13 000	1 525		22 453	6 446	28.7
Emergency preparedness and response	8 037	4 921		111 000	90 106		119 037	95 027	79.8
Essential medicines: access, quality and rational use	18 947	8 529		32 500	18 474		51 447	27 003	52.5
Immunization and vaccine development	16 646	8 025		420 500	296 386		437 146	304 411	69.6
Blood safety and clinical technology	14 135	6 633		10 500	4 936		24 635	11 569	47.0
Evidence for health policy	30 106	14 181		50 500	16 746		80 606	30 927	38.4
Health information management and dissemination	28 662	15 036		17 500	10 156		46 162	25 192	54.6
Research policy and promotion	9 217	4 280		11 000	3 759		20 217	8 039	39.8
Organization of health services	107 466	55 257		52 500	21 935		159 966	77 192	48.3
Governing bodies	21 791	11 168		6 000	3 220		27 791	14 388	51.8

Area of work	Regular budget			Other sources			Total		
	Programme budget 2004-2005	Expenditure 2004	%	Programme budget 2004-2005	Expenditure 2004	%	Programme budget 2004-2005	Expenditure 2004	%
Resource mobilization, and external cooperation and partnerships	22 264	11 842		16 000	11 945		38 264	23 787	62.2
Programme planning, monitoring and evaluation	6 826	3 644		4 500	2 289		11 326	5 933	52.4
Human resources development	16 412	9 426		18 500	11 236		34 912	20 662	59.2
Budget and financial management	22 341	10 599		21 500	15 142		43 841	25 741	58.7
Infrastructure and informatics services	93 715	49 544		81 000	48 507		174 715	98 051	56.1
Director-General, Regional Directors and independent functions	21 670	13 242		7 000	7 052		28 670	20 294	70.8
WHO's presence in countries	111 130	68 926		37 500	16 588		148 630	85 514	57.5
Substantive areas of work – total	846 111	447 113		1 908 000	972 924		2 754 111	1 420 037	51.6
Miscellaneous									
Exchange rate hedging	15 000	14 550		5 000			20 000	14 550	
Real Estate Fund	6 000	5 820			2 563		6 000	8 383	
Information Technology Fund	10 000	9 700		25 000	23 692		35 000	33 392 [a/]	
Security Fund	3 000	2 910		6 000	11 465		9 000	14 375 [a/]	
Miscellaneous – total	34 000	32 980		36 000	37 720		70 000	70 700	
Total – ALL OFFICES	880 111	480 093	54.5	1 944 000	1 010 644	52.0	2 824 111	1 490 737	52.8

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[a/] Funds were transferred from the regular budget and from the Special Account for Servicing Costs to 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 and the Security 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.