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WHO PROGRAMME BUDGET 2004-2005: PERFORMANCE ASSESSEMENT REPORT

1. The Programme budget 2004 – 2005 performance assessment report 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.

7. The Regional Committee is requested to note the report.

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WORLD HEALTH ORGANIZATION

PROGRAMME BUDGET 2004–2005

PERFORMANCE ASSESSMENT REPORT

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FOREWORD

Performance assessment is essential if progress is to be well focused and judged. The Programme budget 2004-2005: performance assessment report provides a valuable perspective on what was accomplished during the biennium. It also indicates where improvements need to be made in the next biennium, and beyond.

To quantify the accomplishments or failures, each area of work forecasts its expected results. The extent to which those expectations are met is a principal indicator of performance. Where evaluation shows that the results fell below expectations, the assessment identifies the reasons, articulates the lessons learnt, and suggests different approaches to be pursued in 2006-2007.

The Secretariat continues to adhere strictly to the principles of transparency and accountability to its Member States. The Programme budget gave priority to building capacity to improve health outcomes, responding to outbreaks and emergencies, tackling health determinants, and strengthening health systems. Numerous events that occurred during the biennium reinforced the appropriateness of those priorities.

WHO responded to a range of natural disasters and crises, including the Indian Ocean earthquakes and tsunamis in December 2004 and the humanitarian crisis in the Darfur region of Sudan. We worked with the international community to mobilize awareness and support for preparedness planning to combat the threat of an influenza pandemic, following the rapid spread of highly pathogenic H5N1 avian influenza in wild and domestic birds across the world. In October 2005 we launched the first global report on preventing chronic diseases,[1] to draw attention to the toll in human life resulting from heart disease, stroke, cancers and diabetes and the role of social determinants of health in their prevention. The reintroduction of wild poliovirus from Nigeria into countries previously free of poliomyelitis, triggered emergency control measures across Africa, including a drive to vaccinate 100 million children in 23 African countries. Responding to these events taxed the capacity of our country and regional offices to the full.

This report gives one perspective on the work of the Organization. Other important and complementary views are offered in annual publications, such as the world health reports, the Report of the Director-General[2] and *World health statistics.*[3] Together, they give a rounded view of the work of the Organization and the progress being made in world health.

LEE Jong-wook
Director-General

Geneva, April 2006

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

[2] *2004: WHO year in review: report of the Director-General.* Geneva, World Health Organization, 2004.

[3] *World health statistics 2005.* Geneva, World Health Organization, 2005.

OVERVIEW

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.

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.

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.

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.

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.

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

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.

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 %.

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.

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.

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.

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.

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.

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

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.

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

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.

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.

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.

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]

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.

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

[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.

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

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.

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.

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.

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.

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.

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.

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

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.

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.

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.

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

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.

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.

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.

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

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

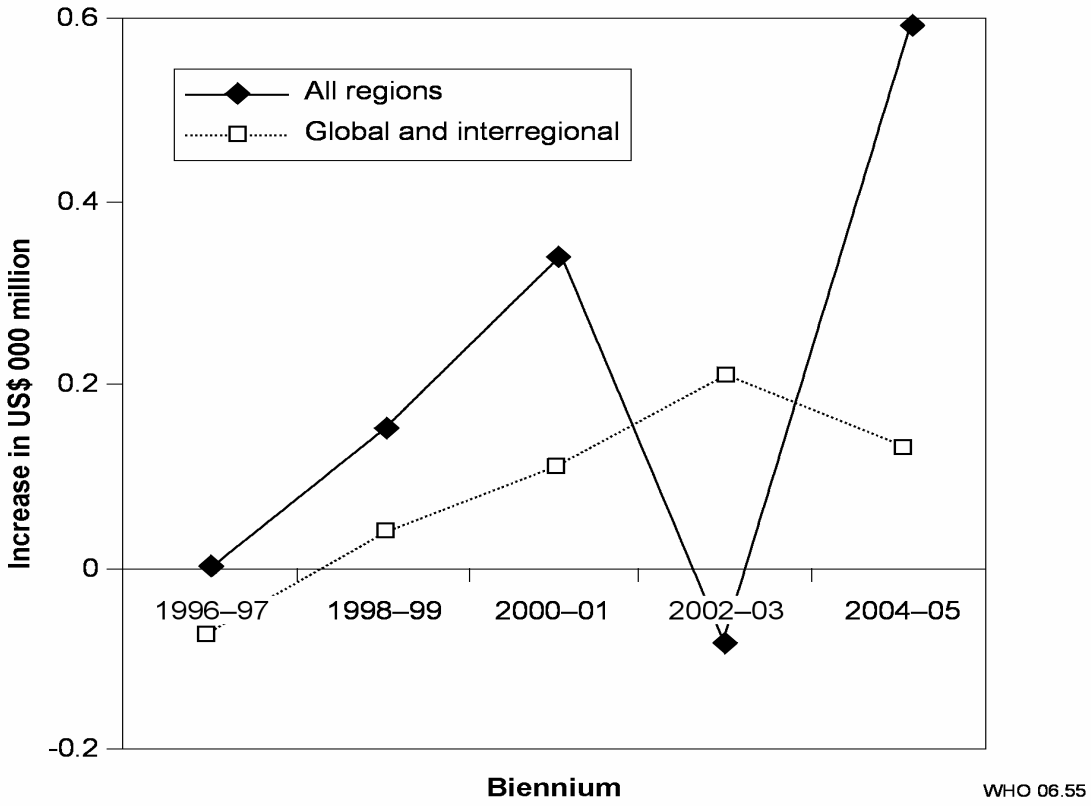
	2002-2003	%	2004-2005	%
COUNTRIES	687	30	1 061	35
REGIONS	609	26	819	27
GLOBAL	1 021	44	1 152	38
TOTAL[1]	**2 317**	100	**3 032**	100
Less eliminations	**267**		**303**	
TOTAL after eliminations	**2 050**		**2 729**	

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

[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.

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.

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



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	
Real Estate Fund	6 000	11 851 [1]	

[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.

Area of work	**Total** (in thousands US$) Programme budget	Expenditure	%
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

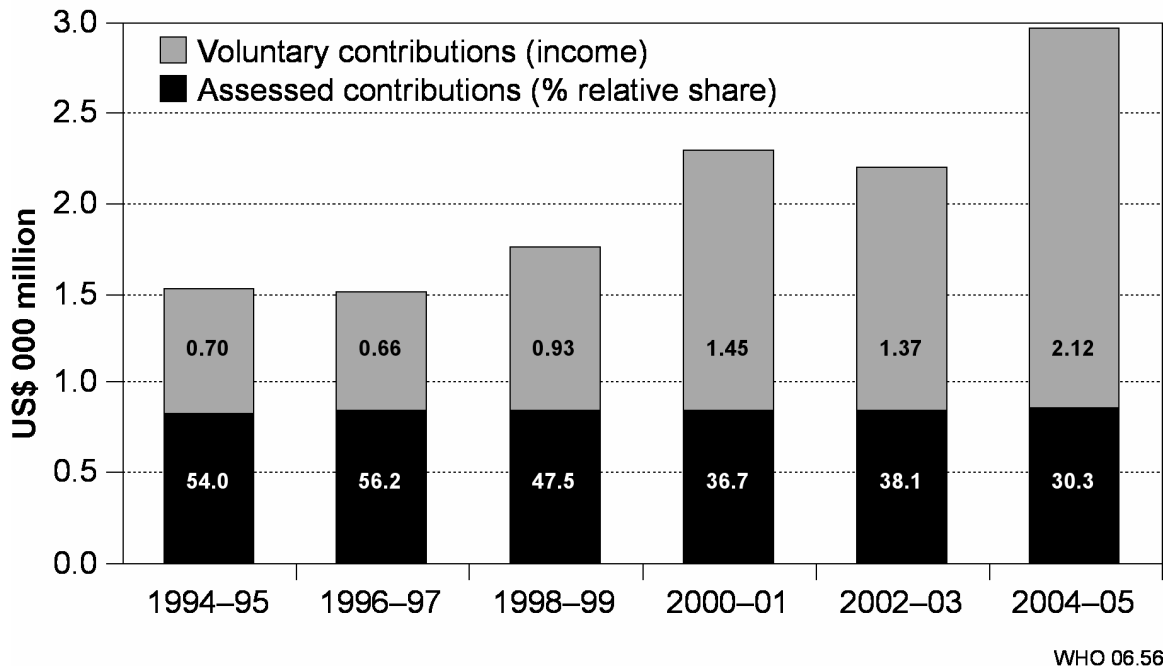
Seventy per cent of expenditure was financed from voluntary contributions of US$ 2100 million (a 61% increase compared to 2002-2003) and the balance from assessed contributions, miscellaneous income, interest income, and carried-forward amounts from the last biennium. Regular budget income in 2004-2005 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%**

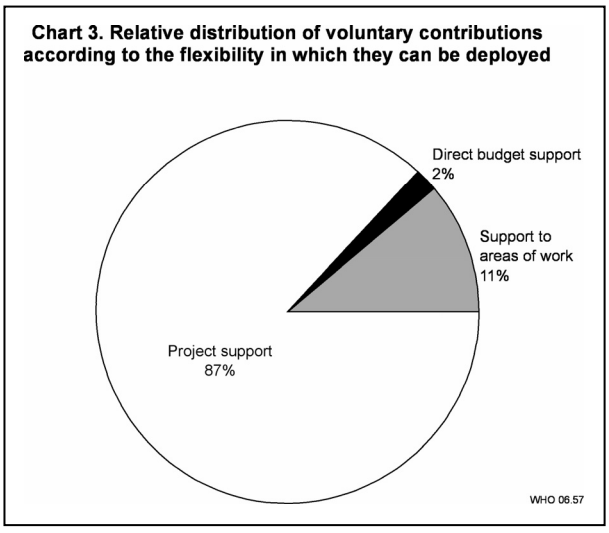
The proportion of overall financing from voluntary contributions reached approximately 70%, compared to approximately 60% in 2002-2003; of this, two thirds was received from 10 Member States. The 12-year trend illustrated in Chart 2, shows that WHO has gradually changed from being predominantly financed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

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



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



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.

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.

PERFORMANCE ASSESSMENT BY AREA OF WORK

COMMUNICABLE DISEASE SURVEILLANCE

WHO objective(s)

To ensure that Member States and the international community are better equipped to detect, identify and respond rapidly to threats to national, regional and global health security arising from epidemic-prone and emerging infectious diseases of known and unknown etiology, and to integrate these activities with the strengthening of their communicable disease surveillance and response systems, national health information systems, and public health programmes and services.

Indicator(s) and achievement

Timely detection of and response to epidemics and emerging disease threats of national and international concern. A total of 654 events with potential importance for international health were identified. The median interval between reception of information and event verification was two days.

Main achievements

- The International Health Regulations (2005) were adopted by acclamation by the Fifty-eighth World Health Assembly on 23 May 2005.[1]
- Each region reviewed and/or updated its surveillance and response strategy, and the regional offices for South-East Asia and the Western Pacific jointly prepared the Asia Pacific Strategy for Emerging Diseases. The Regional Committee for the Western Pacific later endorsed the Strategy, while the Regional Committee for South-East Asia adopted a resolution urging Member States to consider implementation of the Strategy.
- Systematic mechanisms for epidemic intelligence, verification (with 654 events verified), risk assessment, information management and rapid field response were implemented using innovative information technology, standard operating procedures and the mobilization of partners in the Global Outbreak Alert and Response Network.
- Support for avian influenza control and human pandemic influenza preparedness was provided to Member States. Key components of a global action plan to control avian influenza in animals and simultaneously limit the threat of a human influenza pandemic were prepared with FAO. Four main objectives to protect human health were identified: to reduce high-risk behaviours associated with human infections; to improve the detection, investigation, and reporting of human cases and thus strengthen the early warning system; to contain an emerging pandemic virus; and to increase pandemic preparedness. The capacity to manufacture sufficient quantities of pandemic vaccines and antiviral drugs quickly enough and to make these interventions broadly accessible to all countries was another focus of concern.

Illustration of selected achievements

- The Intergovernmental Working Group on Revision of the International Health Regulations successfully completed its work in two meetings held in November 2004 and February 2005 by preparing a draft revised text of the Regulations, which was subsequently adopted by Member States at the Health Assembly in May 2005. The widened purpose and scope are to "prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade." The renewed mandate given to Member States and WHO has broadened their respective roles and responsibilities. In particular, States Parties are required to develop, strengthen and maintain core surveillance and response capacities to detect, assess and report public health events to WHO, and to respond to public health risks and emergencies of international concern. In turn, WHO is to collaborate with States Parties in evaluating their public health capacities, facilitating technical cooperation and logistical support, and mobilizing financial resources for building capacity in surveillance and response.

[1] Resolution WHA58.3.

Achievement of Organization-wide expected results

Advocacy undertaken and partnerships formed to ensure provision of political, technical and financial support to global health security

Indicator	Baseline	Target	Achievement
Number of appearances of global health security initiatives in the international mass media	Not established	Increased appearances in the media	Significant increase but exact number not known
Number of new partners providing financial, political or technical support to global health security	–	5	8

Advocacy initiatives have been undertaken at headquarters and regional levels to ensure provision of political, technical and financial support to global health security. A total of 281 disease outbreak reports were published on the headquarters web site (121 in 2004 and 160 in 2005); and 22 reports focusing on avian influenza and pandemic preparedness appeared on the web site of the Regional Office for the Western Pacific. Each avian influenza outbreak was extensively reported in the media and virtual press conferences were organized to provide additional information. During the last six months of 2005, the number of potential partners interested in supporting global health security increased substantially, mainly because of avian influenza, and culminated in the International Pledging Conference on Avian and Human Pandemic Influenza, held in Beijing in January 2006, where US$ 1900 million were pledged to support countries. In the European Region strong relations were established with the European Centre for Disease Prevention and Control.

Strategies formulated and/or updated and support given for surveillance and containment of known epidemic and emerging disease threats, especially among the poor, including influenza, cholera, meningitis, drug resistance, and those related to deliberate release of biological agents, in close collaboration with WHO collaborating centres

Indicator	Baseline	Target	Achievement
Number of strategies and supporting materials (for example, standards) for surveillance and containment of known epidemic and emerging disease threats available in official and other relevant languages	1 global strategy	Strategy adapted in all 6 regions	Strategy adapted in all 6 regions and a joint Asia Pacific Strategy for Emerging Diseases developed by the regional offices for South-East Asia and the Western Pacific
Proportion of low- and middle-income countries that have received technical cooperation for surveillance and containment of known epidemic and emerging disease threats	60%	80%	80%

The regional offices for South-East Asia and the Western Pacific joined forces to develop and implement the Asia Pacific Strategy for Emerging Diseases. A number of biregional meetings were held during the course of the drafting process, contributing to the successful completion of the document. Almost all low- and middle-income Member States of the Western Pacific Region were recipients of some measure of technical cooperation for surveillance and containment of known epidemic and emerging disease threats. The Regional Office for the Eastern Mediterranean provided technical assistance to Member States to strengthen national public health laboratory capacities in influenza surveillance through the implementation of a trilateral Memorandum of Understanding between the Regional Office for the Eastern Mediterranean, the United States Naval Army Medical Research Unit No. 3 and six Member States: Egypt, Morocco, Oman, Pakistan, Saudi Arabia and Syrian Arab Republic. The Regional Office for South-East Asia provided technical support for a field epidemiology training programme for health personnel in Bhutan, Maldives and Timor-Leste. Twenty countries in the African Region have health workers trained in integrated disease surveillance and response in at least 60% of their districts. Training in integrated disease surveillance and response was made part of applied epidemiology training for senior health personnel in Kenya and Mali, in mid-level health training institutions in Malawi, Mali, Namibia and Uganda and in public health postgraduate training programmes in Ethiopia, Ghana, Uganda and Zimbabwe. In the European Region, country early warning systems were strengthened in Albania, Bosnia and Herzegovina, The former Yugoslav Republic of Macedonia and Serbia and Montenegro.

Alert and response to public health emergencies coordinated in collaboration with affected States and all Member States, WHO collaborating centres, and partners in the global outbreak alert and response network

Indicator	Baseline	Target	Achievement
Number of verified events for which responses provided	95%	100%	100%
Number of technical partners cooperating with WHO in international alert and response	125	140	141

Between 1 January 2004 and 31 December 2005, WHO's system for verification of public health emergencies of international concern identified 654 events of potential importance for international public health. Of those, 478 (73%) were verified, 55 (8%) were unverifiable, 84 (13%) were defined as "no outbreak verified" and 37 (6%) were for information only. The median interval between reception of information and event verification was two days. Most reports were verified within a few days, important events usually within less than 24 hours. In 2004, the Global Outbreak Alert and Response Network supported the following field missions: to China, Thailand and Viet Nam for avian influenza (with the regional offices for South-East Asia and the Western Pacific), to southern Sudan for Ebola virus haemorrhagic fever (with the Regional Office for the Eastern Mediterranean) and to Bangladesh for Nipah-like virus (with the Regional Office for South-East Asia). As part of WHO's health action in crisis, technical input and human resources were also provided in humanitarian crises in Chad and the Darfur region of Sudan. In 2005, 16 field missions were coordinated through the Global Outbreak Alert and Response Network in Angola, Congo, Democratic Republic of the Congo, Guinea, Indonesia, Liberia, Mali, Philippines, Sri Lanka, Sudan, Thailand and Timor-Leste to provide support in the control of outbreaks of yellow fever, dengue and suspected dengue haemorrhagic fever, Ebola, Lassa and Marburg haemorrhagic fevers, myocarditis, plague and meningococcal disease, and in the aftermath of the Indian Ocean earthquakes and tsunamis. Between 1 January 2004 and 31 December 2005, the number of institutions participating in the Global Outbreak Alert and Response Network increased from 126 to 141.

Support provided to strengthen coordinated national communicable disease surveillance systems, including the capability for early detection, investigation and response to epidemic and emerging infectious disease threats, in close collaboration with Member States and WHO collaborating centres

Indicator	Baseline	Target	Achievement
Number of responses made by WHO to requests from countries for technical cooperation in implementation of national surveillance plans, including drawing up of preparedness plans, epidemic intelligence, communications, laboratory capacity, field epidemiology and public health mapping	20% of low-and middle-income countries supported in their implementation of national plans	30%	40%
Number of supporting materials for surveillance system strengthening (for example, guidelines and assessment tools) available in official and other relevant languages	Not established	Not established	Guidelines for infection control, influenza surveillance, response to avian influenza, influenza pandemic preparedness, assessment of early warning functions were developed collaboratively by the regions and headquarters and translated into WHO official languages.

In 2005, all regions sent missions to Member States to support preparation of national pandemic preparedness plans. Meetings, workshops and training sessions were held to improve and enhance country capacity in early detection, investigation and response to epidemic and emerging infectious disease threats, including avian influenza. Assessments of early warning alert and response systems were conducted in Cook Islands, Lao People's Democratic Republic, Malaysia and Mongolia. The Regional Office for Africa, headquarters and the WHO MultiDisease Surveillance Centre in Ouagadougou collaborated to increase surveillance in the African meningitis belt. The training of the fourth cohort of senior public health laboratory personnel from francophone Africa (Benin, Burkina Faso, Djibouti, Mali, Mauritania, Niger and Senegal), organized by the WHO/CSR Office in Lyon, was conducted in Ouagadougou. Guidelines on infection control, influenza surveillance, response to avian influenza, influenza pandemic preparedness, and the assessment of early warning functions were developed collaboratively by headquarters and the regional offices and translated into WHO official languages. To aid the formulation of action plans, a guide for assessing communicable disease risks in countries and prioritizing them on the basis of defined criteria was developed and field-tested in

various Member States of the European and Western Pacific regions. An internet portal was launched for distance follow-up of the training programme for laboratory specialists in the WHO/CSR Office in Lyon.

Revision of the International Health Regulations completed and the new components and guidance for implementation provided to all Member States

Indicator	Baseline	Target	Achievement
Presentation to governing bodies of final draft of revised International Health Regulations by 2004	–	Draft submitted in 2004	Regulations approved in 2005
Mechanisms for assessing core capacities necessary for compliance with the Regulations designed, field tested and implemented in at least two countries in each region	–	Two countries in each region	0

During the revision process, the six regional offices held a total of 11 regional and subregional consultations on the revised draft of the International Health Regulations. Reports of the consultations and written comments from 46 Member States, with submissions by a regional economic integration organization, an intergovernmental agency and three transport industry associations were published on the WHO web site. Following the meetings of the Intergovernmental Working Group on Revision of the International Health Regulations held in November 2004 and February 2005, a draft revised text was presented for consideration by the Fifty-eighth World Health Assembly and was adopted by acclamation on 23 May 2005. However, the delay in approving the Regulations prevented their implementation.

Success factors and impediments

Success factors

- High level of political commitment and increased awareness of importance of timely risk assessment and management by Member States.
- Timely provision of technical support, facilitated by improved detection of disease outbreaks and rapid notification to WHO.
- Activities conducted during previous bienniums and related to national capacity building for severe acute respiratory syndrome preparedness were helpful in the case of other communicable disease threats, particularly avian influenza.

Impediments

- Conflicting priorities such as major outbreaks diverted the attention of staff from implementation of planned activities.
- Challenges in establishing close collaboration between the health and the agricultural sectors at all levels in order to combat H5N1 influenza in poultry and in the human population.
- Communications with currently affected and outbreak-prone countries still need to be improved.
- Difficulty of working in countries with complex emergencies.
- Inadequate financial and human resources and weak health infrastructure.

Lessons learnt in 2004-2005 and how they will be applied in 2006-2007

- The implementation of core capacities for compliance with the International Health Regulations (2005) will require major investment. Building national core capacities for outbreak alert and response, focusing on strengthening national early warning and response systems, and building human resource capacity in key disciplines, for example, field epidemiology and laboratory science, will therefore be critical in the next biennium. Countries have started mobilizing their own resources locally from government and bilateral mechanisms and need to be supported through efforts to increase awareness and provision of additional resource material. The high level of political commitment should be sustained and further strengthened through targeted proactive advocacy and sensitization. The creation of regional subunits for communicable disease surveillance could facilitate further support to countries.
- The implementation of systematic mechanisms for epidemic intelligence, verification, risk assessment, information management and rapid field response using innovative information technology and standard operating procedures and the

mobilization of partners in the Global Outbreak Alert and Response Network have proved to be highly efficient and should continue.

- Strong disease and theme-specific programmes are needed to ensure that key threats are dealt with in a systematic fashion and that WHO maintains the required global expertise in vital areas such as influenza, smallpox, biosafety, deliberate epidemics, meningitis and yellow fever.
- Emerging issues relating to avian influenza responses and influenza pandemic preparedness will need additional resources and support. Good preparedness in terms of emergency stocks, logistics and national rapid response teams has assisted in controlling the spread of outbreaks such as Ebola haemorrhagic fever in the Democratic Republic of the Congo in 2005, and similar approaches should be adopted for influenza pandemic preparedness.
- Standardized approaches for readiness and response to major epidemic-prone diseases such as meningitis, yellow fever and plague should be strengthened in 2006-2007.

Approved budget and actual expenditure

		Approved budget	Actual expenditure		
			Regular budget	Other sources	All funds
Total 2004-2005 (US$ thousand)		94 600	36 311	64 650	100 961
Percentage	countries	26	33	22	26
	regions	37	27	19	22
	global	37	40	59	52

COMMUNICABLE DISEASE PREVENTION, ERADICATION AND CONTROL

WHO objective(s)

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

Indicator(s) and achievement

Number of national programmes functional, focusing on targeted diseases, and significantly reducing morbidity, death, and disability due to these diseases. Several national programmes have been initiated that focus on targeted neglected diseases. This has significantly contributed to reducing morbidity, death and disability from these diseases as described in the achievements below.

Main achievements

- The introduction of the concept of thinking beyond deworming and strategic development of intensified control of neglected tropical diseases. The principles contained in the global strategic framework for integrated vector management[1] are applicable across all vector-borne diseases. Action plans for integrated tropical disease control at district level were outlined in a workshop in Uganda.
- The public-private partnership for human African trypanosomiasis was strengthened and has enabled 28 Member States in which the disease was endemic to follow specific treatment. Of some 30 countries in the African Region in which the disease was endemic, 20 received support to conduct situation analyses and/or initiate or scale up case detection and treatment in priority areas; all the countries involved were supplied with specific drugs for case management. Four and a half million people at risk were examined during the biennium, and as a result 24 000 new cases were detected and treated.
- In the South-East Asia Region, a high-profile partners' and stakeholders' meeting in Bangalore, India, unanimously endorsed a declaration recommending that national governments and national and international agencies should accord high priority to the elimination of neglected diseases and include them in their national development plans to ensure enough policy support for the effort.
- The reconfirmation of the drugs supply for the leprosy elimination programme through a new agreement in 2005.
- The adoption of the Geneva Declaration on Guinea-worm eradication by 2009 at a ministerial round-table meeting convened in Geneva in May 2004.
- The launch of case management with combination therapy (rifampicin-streptomycin) in all 10 countries in the African Region in which Buruli ulcer is endemic.
- The completion of the first round of mass drug administration for lymphatic filariasis elimination with high levels of coverage in all the Mekong-plus countries in the Western Pacific Region.
- The attainment of positive results in dengue control in the Region of the Americas, where 10 countries adopted national programmes aligned with the regional dengue control strategy.
- The preparation of technical guidelines and tools for communicable diseases for use in humanitarian emergencies for seven countries.
- The preparation of standardized guidelines for the diagnosis and treatment of leishmaniasis in the Eastern Mediterranean Region, as well as community education modules on prevention to increase awareness and the chances of early treatment, and to promote the use of bednets.
- The upgrading of the database on zoonotic diseases in the European Region.

[1] *Global strategic framework for integrated vector management.* Geneva, World Health Organization, 2004.

Illustration of selected achievements

The three Mekong countries, Cambodia, Lao People's Democratic Republic and Viet Nam have made significant progress in scaling up their school deworming programmes. Cambodia, thanks to an active partnership with UNICEF and WFP, was the first country in the world to achieve the global objective of regularly deworming more than 86% of primary school children. WHO provided technical support to the deworming campaign through its country-based staff working on the meningitis vaccination project; the Organization also provided financial and logistical support. Key ingredients in this success were the active working relationship forged between the ministries of health and education and the commitment shown by WFP to linking deworming to its school feeding programmes. It remains to be seen whether deworming can become self-sustaining through provinces using their own funds to purchase and distribute the drugs. Given the strength of the current programme there is a good chance that this will happen. Lao People's Democratic Republic, with support from Luxembourg, will be the second country to achieve the global target. In Viet Nam, the Government has allocated US$ 300 000 to increase the scope of its deworming programme with the aim of covering all primary schools.

Achievement of Organization-wide expected results

Evidence-based policies and global and regional strategies formulated for the prevention, control and elimination of targeted diseases; countries adequately supported to adopt and implement such policies and strategies at national and community levels.

Indicator	Baseline	Target	Achievement
Global and regional strategic plans drawn up	Lymphatic filariasis: 1	Lymphatic filariasis: 5	Lymphatic filariasis: 5
Number of targeted countries adopting and adapting for local use WHO policies and strategies (including social mobilization)	Lymphatic filariasis: 36 Schistosomiasis and intestinal parasites: 54 Leishmaniasis: 63	Lymphatic filariasis: 40 Schistosomiasis and intestinal parasites: 60 Leishmaniasis: 88	Lymphatic filariasis: 42 Schistosomiasis and intestinal parasites: 60 Leishmaniasis: 78
Number of countries supported to implement interventions for targeted diseases at all levels	Lymphatic filariasis: 36 Human African trypanosomiasis: 13	Lymphatic filariasis: 40 Human African trypanosomiasis: 36	Lymphatic filariasis: 42 Human African trypanosomiasis: 36

By 2010, approximately 650 million school-age children should be receiving regular treatment with anthelminthics to accomplish the 75% coverage target that Member States were urged to meet by the Health Assembly in May 2001.[1] Although good progress has also been made in terms of coverage of pre-school children, activities should be intensified to reach the target. Data were received from 73 countries in which the targeted diseases are endemic; of these 30 (41%) had made progress in scaling up worm control activities. In countries where parasite control is operational, WHO policies and strategies are being used. Technical support was provided to all countries that expressed an interest in parasitic disease control. Fifty-four countries completed mapping for lymphatic filariasis and another 15 are in the process of completion. Over 100 million individuals are covered by mass drug administration campaigns in 45 countries where lymphatic filariasis is endemic. The principles contained in the global strategic framework for integrated vector management are applicable across all the vector-borne diseases. All 22 countries in the Eastern Mediterranean Region have the necessary guidelines on vector-control interventions. Dengue programme review guidelines were produced. Country reviews and technical guidance for implementation of a global and regional dengue prevention and control strategy received support in Cambodia, the Caribbean, Indonesia and Sri Lanka. Six insecticide products for public health use were evaluated and recommendations made. Evidence-based policies and global and regional strategies for rabies prevention and control in humans and animals were developed in the first report of the WHO Expert Consultation on Rabies.[2] Some 39 countries in which leprosy was endemic, representing 85% of the 46 Member States in the African Region, reached the regional target of a prevalence rate of less than one case per 10 000 of the population. The baseline rate at the beginning of the biennium was 76% (35/46) and the target 100% (46/46).

[1] Resolution WHA54.19.

[2] *WHO Expert Consultation on Rabies: first report.* Geneva, World Health Organization Technical Report Series: 931, 2004.

Adequate technical and policy support provided to endemic countries to improve access to and delivery of crucial public health interventions targeting communicable diseases

Indicator	Baseline	Target	Achievement
Number of endemic countries supported to implement prevention, control and eradication activities	Lymphatic filariasis: 10 Schistosomiasis and intestinal parasites: 39 Leishmaniasis: 63	Lymphatic filariasis: 15 Schistosomiasis and intestinal parasites: 45 Leishmaniasis: 88	Lymphatic filariasis: 19 Schistosomiasis and intestinal parasites: 45 Leishmaniasis: 68
Number of low- to middle-income countries supported to intensify control of neglected diseases	Leishmaniasis: 17 Schistosomiasis and intestinal parasites: 39 Human African trypanosomiasis: 13	Leishmaniasis: 23 Schistosomiasis and intestinal parasites: 45 Human African trypanosomiasis: 36	Leishmaniasis: 22 Schistosomiasis and intestinal parasites: 45 Human African trypanosomiasis: 36

Twenty-one of the 30 countries in which human African trypanosomiasis is endemic (67%) were provided with support by WHO compared with 12 out of 30 (40%) in the previous biennium. Several information and technical materials were developed to strengthen control activities in the field. These included videos, posters and brochures for the general public and community health workers. A manual on the prevention of disability in Buruli ulcer was also completed and will be used in countries to train health workers.[1] For the first time a mass immunization campaign using oral cholera vaccines was conducted as an emergency humanitarian intervention to protect populations at high risk of cholera in the Southern Darfur region of Sudan. Results from the first demonstration project in Beira, Mozambique, using oral cholera vaccine in a high endemic setting were released and showed protective efficacy of 77% six months after vaccination. WHO's response to zoonotic threats, in particular new and emerging threats, such as the unprecedented avian influenza epizootic in Asia was strengthened through the maintenance of an effective working relationship with major international organizations dealing with animal health and food production, for example FAO and OIE, and the establishment of a link between WHO and its regional offices in the veterinary public health domain. The proportion of countries in which Buruli ulcer is either known or suspected to be endemic and that benefited from support for the control of the disease was 30% (6/20); the target was 45% (9/20) against a baseline of 25% (5/20). All 19 countries in which filariasis was endemic were given support to carry out filariasis elimination. Six countries were actively supported in their deworming activities. Four countries received support for schistosomiasis control activities. Only six countries remained in which leprosy was endemic, all the others having eliminated the disease. The main focus in the area of onchocerciasis control has been on integration of the disease in control programmes for other compatible neglected tropical diseases, where possible, using as a vehicle the African Programme for Onchocerciasis Control's approach of community-directed treatment with ivermectin. A closer collaboration with the Programme has been established in this regard.

More alliances and greater mobilization for country-level activities through innovative global, regional and local partnerships

Indicator	Baseline	Target	Achievement
Magnitude of overall increases in funding and support due to participation of existing and new partners	-	10%	2% (US$ 2.5 million)

WHO contributed to the establishment of the charity, Alliance for Rabies Control, which was set up to control rabies through the immunization of dogs. The attention of donors was drawn to and support mobilized for rabies prevention and control at regional and national level in Asia. In the African Region, the Schistosomiasis Control Initiative and two international parasite centres, the Eastern and Southern African Centre of International Parasite Control and the West African Centre for International Parasite Control, actively supported schistosomiasis and soil transmitted helminths control activities in 2004-2005. Burkina Faso, Guinea Bissau, Mali, Mozambique, Niger, Uganda, United Republic of Tanzania and Zambia, all entered into functional partnerships for schistosomiasis and soil transmitted helminths control. In the Western Pacific Region, Lao People's Democratic Republic received funding to allow the scaling up of deworming. In Viet Nam, the Government has provided significant funding

[1] *Buruli ulcer: prevention of disability (POD).* Geneva, World Health Organization, 2006.

for deworming. Three countries will receive new funding from the Asian Development Bank for dengue control starting in 2006. With the exception of 11 Member States in the Western Pacific Region, funding is considered to be inadequate to support lymphatic filariasis elimination. In the Region of the Americas, despite a general lack of attention, funding for some neglected diseases including Chagas disease saw a modest increase.

Control of communicable diseases in countries facing complex emergency situations

Indicator	Baseline	Target	Achievement
Number of complex-emergency countries supported to prevent and control communicable diseases	7	10	12

Field missions were conducted through WHO's communicable diseases working group on emergencies in order to provide technical support on communicable diseases prevention and control and surveillance and response in acute emergencies in the Darfur region of Sudan, the Indian Ocean earthquakes and tsunamis and the earthquake in south Asia, as well as in conflict and post-conflict affected countries and regions (Burundi, Chad, the Democratic Republic of the Congo, Sierra Leone, and northern Uganda). Twelve training workshops on communicable diseases control in emergencies were conducted for WHO's country and regional offices, other United Nations agencies, nongovernmental organizations, international organizations and donor agencies.

New drugs, vaccines, diagnostics or cost-effective interventions developed for the prevention and control of those diseases for which they are still lacking

Indicator	Baseline	Target	Achievement
New or improved drugs for prevention and control, vaccines, and/or diagnostics and guidelines for at least two diseases for which these are still lacking	0	2	1

A project for the production of a cocktail of monoclonal antibodies for rabies prevention was developed in collaboration with the network of WHO collaborating centres. The strategic plan for the elimination of leprosy 2000-2005 supported national programmes by helping them to intensify efforts to diagnose and treat all newly detected leprosy cases with free multidrug therapy drugs. The plan also facilitated the integration of leprosy services into the general health-care system, especially countries in which the disease was highly endemic. The coordination of existing sentinel studies on the burden of foodborne diseases also continued during the biennium. A systematic evaluation of public health impacts was conducted, pre-harvest control of foodborne pathogens such as salmonella and campylobacter was carried out and recommendations on outbreak investigation were developed. Global survey and related laboratory-based surveillance activities were also coordinated and work continued on the establishment of the networks-of-networks for foodborne diseases.

Diseases eliminated as major public health problems, according to respective global or regional targets

Indicator	Baseline	Target	Achievement
Number of countries reaching elimination targets at national, regional or global level	Leprosy: 122 Lymphatic filariasis: 0	Leprosy: 134 Lymphatic filariasis: 1	Leprosy: 128 Lymphatic filariasis: 1

During 2004-2005, a more rigorous strategy to eliminate leprosy as a public health problem helped countries to reduce the burden of this disease. The number of new cases detected globally continues to fall by about 30% each year. Since 1985, more than 14 million patients globally have been cured through multidrug therapy. In the Eastern Mediterranean Region leprosy has been eliminated at the district level in all countries except Egypt. Thirty-five out of 37 Member States in the Western Pacific Region have eliminated leprosy.

Interruption of transmission verified for diseases targeted for elimination at global or regional level, and eradication of dracunculiasis certified

Indicator	Baseline	Target	Achievement
Number of endemic countries in which interruption of transmission of diseases targeted for elimination has been verified	4	12	7
Number of endemic countries in which eradication of dracunculiasis has been certified	150	165	168

The dracunculiasis elimination programme succeeded in reducing the number of cases globally from 32 193 cases in 2003 to 10 491 in 2004-2005 with a drop in the number of countries in which the disease was endemic from 13 in 2003 to nine in 2005. Training for data managers in healthmapping systems for surveillance of nomads in three such countries, Burkina Faso, Mali, and Niger, is now in place. In the African Region, 18 countries in which dracunculiasis was endemic were certified to be free of transmission of the disease. In the Eastern Mediterranean Region, eight out of a total of 21 countries were certified to be free of transmission. In the Western Pacific Region, transmission was interrupted in seven countries in which the disease was endemic.

Success factors and impediments

Success factors

- Close cooperation between headquarters, regional and country offices.
- Availability of drugs free of charge to national programmes has catalysed control activities, resulting in substantial progress towards the control, elimination or eradication of targeted diseases.
- High levels of government, community and family involvement have ensured a strong demand for WHO's programme support.

Impediments

- Short-term funding cycles limited to one year made it difficult to plan activities and provide staff with employment security beyond this period.
- There was inadequate national capacity for programme management and monitoring in some countries.
- Insufficient funding for field activities and insecurity due to armed conflicts were major constraints in some countries.
- Under-reporting has hampered planning, implementation, monitoring and evaluation in the case of some neglected diseases.
- Specified funding has made it difficult to allocate funds where they are most needed especially in critical response and emergency situations.

Lessons learnt in 2004-2005 and how they will be applied in 2006-2007

- Need to promote the integration of neglected tropical diseases wherever feasible in order to achieve improved cost-effectiveness and delivery. Pilot projects with integrated interventions will therefore be initiated in 2006-2007.
- Developing synergies between programmes can help reduce costs. Further synergy will therefore be exploited in the coming biennium.
- Coordination of cross-border and refugee issues are crucial to sustain achievements and prevent outbreaks following refugee movements. Reinforcement of these activities is planned in 2006-2007.

Approved budget and actual expenditure

		Approved budget	Actual expenditure		
			Regular budget	Other sources	All funds
Total 2004-2005 (US$ thousand)		134 286	20 573	80 196	100 769
Percentage	countries	30	34	14	18
	regions	38	29	63	56
	global	32	37	23	26

RESEARCH AND PRODUCT DEVELOPMENT FOR COMMUNICABLE DISEASES

WHO objective(s)

To generate new knowledge and tools (including vaccines, drugs and diagnostics, intervention methods and implementation strategies) for the prevention and control of communicable diseases, whose application is gender sensitive and oriented towards poverty reduction and which can be incorporated into the health systems of disease-endemic countries; and to build local health research capacity for better tackling the complicated health problems in these countries.

Indicator(s) and achievement

- *Increase in level of knowledge on and number of new solutions to public health problems of the disease-endemic countries produced from research and development.* No data available.
- *Increase in level of participation of researchers from disease-endemic countries in international efforts to generate new knowledge and solutions to the public health problems affecting these countries.* No data available.

Main achievements

- There has been significant progress in communicable disease research across the full research spectrum from basic to implementation research, as well as in research capacity building. The median achievement rate per indicator was 67% of the target value, which corresponds to the available budget, which was also 67% of the target.
- There has been significant progress with ongoing research activities. Examples include testing of fixed-dose combination treatment of malaria with chlorproguanil/dapsone (LAPDAP) plus artesunate in phase III trials, testing of gatifloxacin-containing combination treatment for tuberculosis in phase III trials, testing of moxidectin for onchocerciasis in phase II trials, and the launching of new studies to assess efficacy of treatment with artemether-lumefantrine in pregnant women with malaria.
- Preliminary results of ongoing implementation research indicate that community-level use of artemisinin-based combination therapy (ACT) is feasible, acceptable and achieves high compliance, that local partnerships can effectively deliver drugs in urban settings in India, and that communities in Africa are keen to use community-directed strategies for integrated delivery of multiple disease interventions.
- Capacity-building activities were successfully conducted, including special training initiatives for social science research methods, bioinformatics and applied genomics, epidemiology, project management and clinical monitoring.

Illustration of selected achievements

At the Fifty-eighth World Health Assembly in May 2005 the Health Ministers of Bangladesh, India, and Nepal, signed a formal Memorandum of Understanding pledging to work together to eliminate visceral leishmaniasis in their countries by 2015. A major driving force behind this decision was the development of the oral drug miltefosine (registered in 2002 through a partnership between Zentaris, the Indian Council of Medical Research and the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR)), which opens up the possibility of out-patient treatment, together with several diagnostic tools (undergoing comparative evaluation by TDR) and other tools in the process of development, e.g. paromomycin (in partnership with the Institute for OneWorld Health). In addition to the availability of these tools, elimination will require coordinated action by many players at country level and implementation research to support, inform and help integrate the scaling up of control activities. This activity is now being driven by national programmes under the guidance of a Regional Office for South-East Asia committee whose mission is to assist in managing multicountry, cross-border issues.

Achievement of Organization-wide expected results

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

Indicator	Baseline	Target	Achievement
Number of new and significant advances	500	300	446
Number of patents resulting from research and development funded by the Special	4	5	1

Indicator	Baseline	Target	Achievement
Programme for Research and Training in Tropical Diseases			
Number of outstanding advances in scientific knowledge	12	5	15

A total of 446 scientific articles that resulted from TDR-supported research projects were published in peer-reviewed scientific journals. *Schistosoma mansoni* antigen Sm14 was patented in 7 countries for use in vaccine development. Among the outstanding advances in scientific knowledge are improved understanding of the genetic basis for clinical presentations in leishmania infection; the progress of the *Glossina* genome project to the sequencing phase; the discovery of new drug leads for tropical diseases, notably for onchocerciasis and malaria; evidence on the safety of coadministration of a single dose of praziquantel, ivermectin and albendazole; and a published review of gender in tropical diseases.

New and improved tools, including drugs, vaccines and diagnostics, devised for prevention and control of infectious diseases

Indicator	Baseline	Target	Achievement
Number of new and improved tools, such as drugs and vaccines, receiving regulatory approval and/or label extensions or, in the case of diagnostics, being recommended for use in controlling neglected tropical diseases	3	5	3
Number of new and improved epidemiological and environmental tools being recommended for use in controlling neglected tropical diseases	0	2	0

Regulatory approval was obtained for the label extension of artemether-lumefantrine that now allows "on label" recommended use of the drug for young children from 5 kg in weight, as opposed to 15 kg in the original package insert. Several existing syphilis tests were demonstrated to have adequate sensitivity, specificity and ease of use, and were placed on WHO's procurement list. This led to a reduction in price and increased interest in utilizing the tests for detection of congenital syphilis. Plans to eliminate congenital syphilis as a public health problem are now being developed in Brazil, China, Haiti and the United Republic of Tanzania. Three tests for case management of visceral leishmaniasis were tested in field sites in Ethiopia, India, Kenya, Nepal and Sudan. One of the tests, rK39, had acceptable sensitivity and specificity to be used for case management of visceral leishmaniasis in the Indian subcontinent, but cannot be recommended for use in Africa owing to its lower sensitivity.

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

Indicator	Baseline	Target	Achievement
Number of new and improved intervention methods validated for prevention, diagnosis, treatment or rehabilitation, for populations exposed to or affected by infectious diseases	0	5	2

Evaluation of 19 marketed serological diagnostic tests for tuberculosis showed that all lack acceptable performance for the detection of tuberculosis and none can be recommended as a replacement for smear microscopy or used in settings without laboratory services. A multi-centre study on entomological sampling methods for dengue surveillance showed that a pupal survey method was able to identify the most productive water-container types, which produce more than 70% of pupae. The use of this tool would allow more cost-effective vector control by targeting the most productive water containers and better prediction of the risk of epidemic dengue transmission.

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

Indicator	Baseline	Target	Achievement
Number of new and improved public health strategies for which effectiveness has been determined, and evidence on effectiveness made available to decision makers	2	2	3
Number of new and improved policies and strategies for enhanced access to public health interventions formulated, validated and recommended for use	2	3	0

A large-scale study in South Africa showed that the introduction of ACT led to a major reduction in malaria cases and deaths attributable to malaria. The cost per life saved was estimated at US$ 18 with ACT, compared to US$ 158 with conventional drugs. Data on in-vivo monitoring of therapeutic efficacy of antimalarial drugs in 41 malaria-endemic countries in Africa provided further evidence for updating malaria treatment policy to ACT in 25 countries. Administration of ivermectin for the purpose of onchocerciasis control can result in severe adverse reactions in individuals with a high level of *Loa loa* infection. A non-invasive, questionnaire-based strategy for determining the level of loiasis endemicity and the related risk of adverse reactions has been developed in four African countries. The strategy was adopted by the African Programme for Onchocerciasis Control and its large-scale application has enabled ivermectin distribution to be re-established in many parts of Africa. Longitudinal studies of the impact of mass drug administration on lymphatic filariasis transmission and infection showed dramatic declines in infection in all locations where the programme has been implemented. However, the impact on transmission is variable and it was concluded that in many settings, more than the currently recommended four to six years of mass drug administration will be required to achieve elimination of transmission.

Partnerships established and adequate support provided for strengthening capacity for research, product development and application in disease-endemic countries

Indicator	Baseline	Target	Achievement
Number of people trained	716	859	547
Number of research institutions in low-income disease-endemic countries strengthened	4	6	4
Proportion of partners from disease-endemic countries to the total number of partners	72%	65%	77%
Proportion of total new and significant scientific advances produced by scientists from disease-endemic countries	49%	45%	57%

The number of postgraduates met the target but the number of persons trained in short courses (492) fell short of the target of 800, largely as a result of the budget shortfall (see below). The participation of scientists from disease-endemic countries in the research effort was very strong and substantially exceeded the targets set for the biennium.

Adequate technical information and research guidelines accessible to partners and users

Indicator	Baseline	Target	Achievement
Number of global research priority-setting reports and research guidelines for neglected infectious diseases published	15	12	20
Mean monthly number of page views to the Special Programme pages on the WHO web site	133 968	200 000	296 061

The reports of two scientific working groups were published, reviewing the global research needs and priorities for malaria and leishmaniasis respectively. TDR published another 18 research guidelines and instruments for tropical diseases research.

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

Indicator	Baseline	Target	Achievement
Resources for research, product development, and capacity-building priorities	US$ 71.3 million	US$ 100 million	US$ 67.2 million

Only two thirds of the target budget for 2004-2005 was funded. Undesignated contributions to TDR continued to decline and 42% of the available funds were designated to specific research activities. The decrease in the proportion of undesignated funds has restricted TDR's ability to respond to priority needs and research opportunities.

Success factors and impediments

Success factors

- Effective research partnerships were established, especially with disease control programmes and industry.
- The greater role of researchers from disease-endemic countries has ensured greater relevance of research findings.
- Improved global priority-setting has improved the cost-effectiveness of research efforts by focusing them on priority needs for disease control.

Impediments

- Shortage of funds: only two thirds of the budget was funded.
- Demands for research and engagements in partnerships greatly exceeded the available financial and human resources.
- Research capacity in disease-endemic countries is still very inadequate.

Lessons learnt in 2004-2005 and how they will be applied in 2006-2007

- The research environment is rapidly changing, with many new actors entering the field, e.g. public-private partnerships in product development. TDR is developing a new overall strategy that will address those changes and build on TDR's comparative advantage in specific research areas, capacity building, priority setting and knowledge management.
- TDR has been attempting to do too much with too few resources. The new strategy will ensure greater focus on a smaller number of priority issues while strengthening fund-raising for tropical diseases research.
- In spite of the major achievements, the full extent of WHO's research activities in tropical diseases is not widely known. New communication and advocacy initiatives will therefore be launched in 2006 and 2007.

Approved budget and actual expenditure

		Approved budget	Actual expenditure		
			Regular budget	Other sources	All funds
Total 2004-2005 (US$ thousand)		114 468	3 350	70 836	74 186
Percentage	countries	3	1	0	0
	regions	7	10	1	2
	global	90	89	99	98

MALARIA

WHO objective(s)

To encourage and support the scale up of effective action to roll back malaria and to facilitate operations of the Roll Back Malaria partnership.

Indicator(s) and achievement

- *Malaria prevalence rate and malaria-related death rate in children under five.* The number of malaria episodes was estimated at 350 million to 500 million per year in 2004. Malaria-related deaths among children under five in Africa were estimated at 710 000 to 896 000 for the year 2000.
- *Proportion of children under five in malaria-risk areas using effective malaria prevention (primarily insecticide-treated nets) and proportion having access to appropriate treatment.* Surveys conducted between 1999 and 2004 indicated a median insecticide-treated nets use of approximately 3% (range: 0.1% to 63%) for children under five in sub-Saharan Africa.
- *Level of financial resources available to support scaling up malaria control and prevention strategies.* A median of 8% of national health expenditure was dedicated to malaria. Globally, some US$ 205 million was made available for malaria control in 2004 through international transfer.

Main achievements

- During the biennium, 43 countries adopted artemisinin-based combination therapies (ACTs) for treatment of falciparum malaria, bringing the total to 56, 26 of which are in Africa. Implementation of ACT policies has started in 29 countries, 10 of them in Africa. A crisis of supply in late 2004 had been overcome a year later, and in 2005 about 30 million courses of the combination therapy were procured by endemic countries, compared with 4 million in 2004. A Malaria Medicines and Supply Service was established to deal initially with ACTs and subsequently long-lasting insecticidal nets. With WHO support, the cultivation of *Artemisia annua* in eastern Africa was expanded so as to meet about 20% of world market demand.
- A global report on antimalarial drug resistance based on collaborative monitoring in more than 60 countries was published in August 2005.
- Guidelines and quality assurance methods for malaria microscopy were reviewed and the central laboratory for malaria diagnosis in Oman was identified as a potential Regional Centre of Excellence in the Eastern Mediterranean Region. A network of rapid diagnostic test quality-assurance laboratories was established in the Western Pacific Region with support from headquarters; instructions, training material and methods for rapid diagnostic testing and products were developed, with support from a global network of scientific institutions. In the South-East Asia Region, all Member States introduced rapid diagnostic tests to supplement microscopy.
- The African insecticide treated nets scale-up began in 2005, with a total of 25 million nets distributed in countries in which malaria was endemic, thanks to major increases in disbursements. Related achievements include WHO-UNICEF advocacy for free or highly subsidized distribution for vulnerable groups, combined campaigns in several African countries, and the availability of two WHO Pesticides Evaluation Scheme-validated brands of long-lasting insecticidal nets. With financial support from the Netherlands, WHO, UNICEF and the International Federation of Red Cross Red Crescent Societies supported health ministries in Burkina Faso, Chad, Madagascar and Mali in delivering long-lasting insecticidal nets together with routine immunization under the Extended Programme and National Immunization Days: some 383 000 such nets were distributed to children under five years of age; malaria prevention in pregnancy was supported in Burkina Faso, Gambia, Guinea-Bissau and Madagascar with 87 000 long-lasting insecticidal nets and 600 000 sulfadoxine-pyrimethamine tablets for intermittent preventive treatment were provided through antenatal care services; and mass mosquito-net treatment/re-treatment was implemented in the six countries mentioned, targeting over two million nets. "Quick-win" initiatives for rapidly achieving universal coverage of insecticide-treated nets in Africa led to high-level international discussions, informed by WHO analyses of financial, supply and system-building requirements.
- A strategic plan, guidelines and tools for vector-control needs assessment for the Eastern Mediterranean Region were finalized. Other regions are preparing integrated vector management projects to provide platforms for intersectoral and intrasectoral collaboration and resource mobilization.
- WHO collaborated with the United Arab Emirates on certification, and elimination programmes were supported in Saudi Arabia, the Islamic Republic of Iran and Iraq. In the European Region, where the reported number of malaria cases was almost halved in the biennium, a regional declaration on "The move from malaria control to elimination" was endorsed by malaria-affected countries in 2005. In the Region of the Americas the reported over-50% level of reduction in cases (compared to the year 2000) was maintained during the biennium in eight of the 21 endemic countries while an additional

seven countries reported a case reduction of less than 50%. Additionally, re-emergence of transmission in countries where elimination had been certified was successfully prevented throughout the biennium.

- An inter-agency handbook on "Malaria control in complex emergencies" was published in December 2005[1] and a technical network on this topic launched under WHO leadership. A report on a technical consultation on malaria epidemics was published.[2]
- In 2004, for Round 4 of the Global Fund to Fight AIDS, Tuberculosis and Malaria, WHO supported the preparation of 15 of the 26 successful malaria proposals (14 of them in Africa). For Round 5 in 2005, WHO supported 35 countries in the preparation of proposals; 14 were successful, and US$ 208 million was thereby added to the total of US$ 995 million from the first four rounds. WHO country staff provided continuous support to practically all Global Fund malaria-grant recipients and a web-based information system to track country performance was set up in 2005.
- The first World Malaria Report, launched on 3 May 2005, included a new estimate of the malaria burden in the world. The Regional Office for Africa published the first progress report on implementation of the Abuja Declaration Plan of Action with data covering the period up to 2005. The global database on malaria was expanded to include main indicator data on control implementation. Malaria control surveys were supported in nine Member States of the African Region, in two Member Sates of the Eastern Mediterranean Region (Somalia and Sudan) and in three in the Western Pacific Region (Cambodia, China and Lao People's Democratic Republic). WHO also played a leading role in programme reviews in Myanmar and the Philippines in 2005.
- In 2005 the Fifty-eighth World Health Assembly adopted resolution WHA58.2 calling for a minimum of 80% coverage with major malaria-control interventions by 2010. This was echoed by the resolution on the Decade to Roll Back Malaria in Developing Countries, Particularly in Africa, adopted by the United Nations General Assembly in December 2005, and by the Roll Back Malaria Partnership's Global Strategic Plan 2005-2015, adopted as part of the Yaoundé Call to Action at the Roll Back Malaria Partnership Forum V in Yaoundé in November 2005.
- In 2005, two Roll Back Malaria concerts, one in Dakar in March, and one in Geneva in October, attracted world media attention.

Illustration of selected achievements

In 2004 there were 1.6 million internally displaced people in the Darfur region of Sudan, which has seasonal malaria transmission. In May, before the malaria season, WHO issued guidelines on malaria prevention and control in Darfur, for national services, international partners and nongovernmental organizations. Under WHO guidance, artemisinin-based combination therapy was instituted together with rapid diagnostic tests and home visits, camps were sprayed reaching 85% coverage before the transmission season, insecticide-treated nets were distributed, ponds were drained, and weekly surveillance established. From May to October 2004, a total of 118 384 malaria cases (attack rate of 7.4/100) and 215 malaria deaths were recorded. The case fatality rate of 0.2 % was lower than the current rate in most endemic countries.

Achievement of Organization-wide expected results

National authorities able to scale up cost-effective and sustainable malaria-control measures, as part of or closely linked to health systems development

Indicator	Baseline	Target	Achievement
Proportion (%) of malaria-endemic countries adopting strategy on use of insecticide-treated nets in which at least 60% of targeted populations are protected by such nets	10%	30%	61% (30 of 49 endemic countries in Africa) have a strategy with a minimum 60% coverage target. Five reached that target, namely Eritrea, Gambia, Malawi, Niger and Togo
Number of countries implementing artemisinin-based combination therapies as first-line and/or second-line treatment of falciparum malaria	13	40	29 of the 56 countries that adopted ACTs are deploying the medicines. Another 27 countries adopted ACT policies but are not yet implementing them

[1] *Malaria control in complex emergencies: an interagency field handbook*. Geneva, World Health Organization, 2005.

[2] *Malaria epidemics: forecasting, prevention, early detection and control: from policy to practice: report of an informal consultation, Leysin, Switzerland 8-10 December 2003*. Geneva, World Health Organization, 2004.

Mechanism established that empowers communities, particularly the poorest, to take appropriate action to increase and sustain control of malaria

Indicator	Baseline	Target	Achievement
Number of countries that implement communications strategies endorsed by all partners which support the achievement of the targets set out in the Abuja Declaration on Roll Back Malaria in Africa	0	14	40 African countries with significant malaria burden moved from communication strategies around "strategy and policy" of malaria control towards communication strategies around "scaling-up for impact"

Unprecedented progress was recorded during the biennium in terms of rational policy-making for all malaria interventions and to some extent also for delivery, especially of insecticide-treated nets in the African Region. In addition, home management is now implemented in 15 countries in the Greater Mekong Subregion, with systematic activities to strengthen programmes' community communication. In general, however, the accelerated delivery of malaria control interventions is not matched by any corresponding strengthening of demand-creation or community involvement.

A system for routine monitoring of malaria and control measures established in all countries endemic for malaria

Indicator	Baseline	Target	Achievement
Proportion of malaria-endemic countries with effective monitoring system for malaria cases and deaths, and reporting annually to WHO	80/105 (75%) for 2001	90/105 (85%) for 2004	(46%) (48 of 105 countries) provided data on malaria cases and/or deaths for 2004 by the end of 2005
Proportion of malaria-endemic countries with nationally representative household surveys conducted for monitoring coverage of insecticide-treated nets and access to effective treatment within 24 hours	43% (45/105)	60% (63/105)	48% (32 of 105 countries); Demographic Health Surveys/Multiple-indicator Cluster Surveys conducted in five countries in 2004 and in 27 countries in 2005
Number of countries at risk of epidemics of malaria that have a resourced malaria epidemic preparedness plan in accordance with WHO guidelines	5	15 of 25 epidemic-prone African countries	15 of 25 epidemic-prone African countries developed epidemic preparedness plans

There has been tangible progress in this area, with the World Malaria Report and the report on the attainment of the Abuja targets. Monitoring and evaluation have also been strengthened, with more and better surveys in Member States in all regions. Yet reporting is still incomplete, with excessive delays in most countries; very few countries have a fully functional, quality-controlled malaria surveillance system. While 15 of 25 African countries have developed epidemic preparedness plans, most of them remain partially or completely unfunded.

Both global advocacy on the importance of malaria and efforts to increase resources available for its control supported

Indicator	Baseline	Target	Achievement
Number of malaria-affected countries with an agreed national advocacy strategy for rolling back malaria	35	44	43 qualifying African countries with a significant malaria burden mobilized additional resources through the Global Fund. The non-qualifying countries are Algeria, Botswana, Egypt, and South Africa

The global malaria problem probably received more media coverage worldwide than ever before, and major new initiatives were launched by the President of the United States and the World Bank. Much of the press coverage was negative, however, accusing WHO and the Roll Back Malaria Partnership of making insufficient progress.

Technical standards established for malaria control and provision of technical support to countries ensured

Indicator	Baseline	Target	Achievement
Number of malaria-endemic countries implementing integrated vector management for malaria control in accordance with WHO guidelines	36	54	15 countries held in-country consensus meetings on integrated vector management (out of 24 sensitized to the need for policy change and formally committed to pilot implementation)

Most endemic countries received some technical support from WHO, the effectiveness of which was, however, limited by the scarcity of highly qualified WHO technical staff at country level. Much-needed technical guidance documents on case management and vector control were finalized in 2005 for publication early in 2006.

High-priority research and development areas supported, including combination treatment, diagnostic tests, treated nets with longer-lasting insecticidal activity, and intermittent preventive treatment, and results incorporated into national plans

Indicator	Baseline	Target	Achievement
Number of countries having generated evidence-based strategies for rolling back malaria	9	20	35 countries, representing all African countries not affected by complex emergencies, achieved this indicator

Good progress was made in quality assurance on rapid diagnostic tests and on assessment of long-lasting insecticidal nets, but in general, lack of funds was a severe constraint on assessments of safety of new medicines and implementation and operational research.

Capacity developed within countries for policy-making, programme management and social mobilization

Indicator	Baseline	Target	Achievement
Number of malaria-endemic countries from which data on human resource needs are gathered and analysed	0	5	3 (Malawi, Rwanda and Somalia)
Number of malaria-endemic countries that benefited from strengthening the capacity-development skills of national-level health staff (transfer of training technology)	3	17	1 (Ethiopia)
Number of national consultants/national professional officers trained in HIV/AIDS, tuberculosis and malaria and providing coordinated technical and programmatic support to the national control programme/Roll Back Malaria Partnership	0	17	25 national professional officers and international programme officers from African countries trained in 2004
Number of countries where local training institutions were strengthened for national and district capacity development activities	2	18	Training not delivered at country level. However, a workshop on district malaria control was conducted and a district handbook for malaria control drafted

Outcome-oriented international training activities were supported in all regions. Progress was made on the preparation of a district-level training kit. Attention was given to building capacity in WHO, especially of national professional officers. Nazareth Malaria Training Centre, Ethiopia, benefited from institutional strengthening to conduct an International Course on Malaria and Planning its Control for anglophone participants in 2005.

Success factors and impediments

Success factors

- The African Region country-support structure was strengthened, with improved staffing and clear demarcation of responsibilities and lines of communication between country, intercountry and regional levels, and the appointment of team

coordinators at the Regional Office; a well-structured regional unit with strong country staff is also seen as an essential success factor in the Regional Office for the Western Pacific.

- Teleconferencing permitted instant discussions and improved coordination between intercountry teams, the Regional Office for Africa and headquarters.
- High political commitment from some countries enabled national resources to be allocated.
- WHO international field staff have a strong presence in some countries in which malaria is endemic.
- Adequate extrabudgetary funding was available for certain priority regional activities and intercountry initiatives, especially in the African, European and Western Pacific regions.
- Adequate financing is now available for some national programmes.
- Bilateral collaboration exists between some countries (e.g. Saudi Arabia and Yemen).
- Global Fund applications for Rounds 4 and 5 required an ACT treatment policy, which facilitated decision-making by countries.
- Well-coordinated involvement of partners with complementary strengths existed in some countries.

Impediments

- Lead time for procurement and shortage of ACTs delayed implementation of new policies in several countries; likewise, limited availability of long-lasting insecticidal nets slowed down implementation.
- There was an overall shortfall in the WHO malaria control budget to meet the level of activities required to facilitate scale-up in countries. Budget cuts are taking effect at all levels.
- There is a lack of funds for recruiting or retaining international WHO staff where the complexity of the malaria situation and the weakness of national programmes make this absolutely necessary. For some regions, this is related to huge reductions in the budget transferred from headquarters.
- The staff country quota system poses problems of continuity of some staff. Unstructured and uncoordinated technical support by partners in the African Region led to duplication and over-burdening of some national authorities.
- In the South-East Asia and Eastern Mediterranean regions, most proposals for Round 5 of the Global Fund were rejected, although their quality was often at least as good as that of some that had been accepted in previous rounds. This has created frustration in countries.
- Transfer of funds to countries from the Global Fund is sometimes excessively slow and bureaucratic.
- Inadequate human resources are available at the various country levels, in terms of quality and quantity, particularly for planning and management, delivery of vector control interventions and malaria microscopy.
- Many countries have weak monitoring and evaluation systems, lack baseline data on coverage indicators and have insufficient funds for surveys needed.
- Complex emergency situations, especially in some Member States in the African and Eastern Mediterranean regions, hinder access to malaria-endemic areas, especially for external consultants.
- The quality of some activities suffers through the poor availability of Global Fund support in countries facing huge implementation and performance pressures, and there is a danger that the implementation of WHO priority activities may be delayed or cancelled.

Lessons learnt in 2004-2005 and how they will be applied in 2006-2007

- Intensive, well-focused advocacy is required to promote adoption of effective policies at country level.
- Partnering with institutions with complementary comparative advantage is critical to ensure achievement of objectives.
- Partnerships need to be managed closely to ensure that a clear vision is shared by all.
- Especially for countries outside tropical Africa, there is a need for WHO to issue a clear methodology for estimating malaria burden and for surveillance, monitoring and evaluation, with a limited number of clear indicators.
- The will to move from malaria control to elimination at national level, and the availability of efficacious tools, may facilitate decisions to undertake new elimination efforts in the European and Eastern Mediterranean regions.
- Continuity of WHO international staffing in key countries needs to be ensured.

- Experiences and lessons learnt from the strong Greater Mekong Subregion country network need to be better shared with other Member States in the South-East Asia and Western Pacific regions – especially with the latter, where malaria incidence is highest.
- WHO needs to focus more on the private sector, which is thriving in the Region and in which most malaria treatments take place in many countries. In so doing, efforts will be made to develop appropriate approaches in cooperation with other WHO programmes.

Approved budget and actual expenditure

		Approved budget	Actual expenditure		
			Regular budget	Other sources	All funds
Total 2004-2005 (US$ thousand)		126 140	19 464	137 200	156 669
Percentage	countries	26	39	24	26
	regions	45	32	22	23
	global	29	29	54	51

TUBERCULOSIS

WHO objective(s)

To strengthen technical and financial support to countries, based on the global DOTS expansion plan; to increase access to high-quality drugs through the Global TB Drug Facility; to facilitate Stop TB partnership operations; to accelerate the development of specific interventions, strategies and policies for DOTS expansion, dual tuberculosis/HIV infection, multidrug-resistant tuberculosis, and increased involvement of communities, local nongovernmental organizations, private practitioners and primary care workers; to lead global surveillance, monitoring and evaluation; and to promote, and act as a catalyst for, research on new diagnostics, drugs and vaccines.

Indicator(s) and achievement

DOTS implementation rates and global DOTS coverage. At the end of 2004, DOTS, which remains at the heart of the new Stop TB Strategy, was being applied in 183 countries; population coverage was complete in nine of 22 high-burden countries and nearly complete in five others.

Global case detection and cure rates. Global case detection rates were 53% for 2004 and are likely to exceed 60% for 2005. Treatment success was 82% in the 2003 cohort of 1.7 million patients, approaching the 2005 target of 85%.

Global financial resources available for tuberculosis control activities. Increases in domestic and international funding meant that financing for tuberculosis control, in the 22 countries with the highest burdens due to the disease, increased from just over US$ 900 million in 2004 to US$ 1200 million in 2005.

Main achievements

- Increased support was provided to all regions to accelerate DOTS expansion, and in 2005 a new Stop TB Strategy, built around DOTS, was developed and endorsed by the WHO Strategic and Technical Advisory Group for Tuberculosis, as were international standards for tuberculosis care.[1]
- The Global Plan to Stop TB 2006-2015 was developed in close collaboration with partner organizations, and a large proportion of the objectives of the first Global Plan to Stop TB 2001-2005 were achieved.
- Global case detection and cure rates continued to be monitored and profiled in the annual WHO reports – *Global tuberculosis control: surveillance, planning, financing* 2004 and 2005.
- The Stop TB Partnership grew to over 400 partners and a Stop TB Trust Fund was established, with long-term funding agreements signed with several donors.
- The Partnership's Global TB Drug Facility delivered more than six million patient treatments to 70 countries.

Illustration of selected achievements

Substantial progress towards the global tuberculosis control targets was achieved in the South-East Asia and Western Pacific regions. In the South-East Asia Region, case detection increased to 59% by the end of 2004 and exceeded 60% by the end of 2005. Treatment success has already surpassed the global target of 85%. In the Western Pacific Region, case detection and treatment targets for 2005 are expected to have been met. Collaboration with the private sector and nongovernmental organizations resulted in expansion of DOTS beyond the public health services, increasing case detection by 24% on average. Tuberculosis/HIV collaborative activities and multidrug-resistant tuberculosis treatment projects are being established. The Regional Office for South-East Asia developed a 10-year regional strategic plan to guide countries' planning to reach the Millennium Development Goals for tuberculosis. The Western Pacific Region is finalizing a regional strategic plan for 2006-2010 that aims to reduce prevalence and mortality due to tuberculosis by one half by 2010, in line with goals set by the Regional Committee for the Western Pacific and the Millennium Development Goals.

Achievement of Organization-wide expected results

Global DOTS expansion plan maintained and expanded, underpinned by the Global Plan to Stop TB, comprising shared goals and values

Indicator	Baseline	Target	Achievement
Global case detection rate of new smear-positive cases in DOTS programmes	45%	70%	53% (2004)[1]

[1] *International standards for tuberculosis care.* The Hague, Tuberculosis Coalition for Technical Assistance (TBTCA), 2005.

Indicator	Baseline	Target	Achievement
Global treatment success rate of new smear-positive cases in DOTS programmes	82%	85%	82% (2003 cohort)

The Region of the Americas and the South-East Asia and Western Pacific regions are expected to have met both of the 2005 targets. The Millennium Development Goals target 8 for tuberculosis is to have halted and begun to reverse incidence by 2015. The Stop TB Partnership has endorsed additional targets for 2015 of halving tuberculosis prevalence and deaths compared with 1990 levels. Implementation of the Global Plan to Stop TB 2006–2015 is expected reach these targets except in Africa and eastern Europe.

National partnerships in the form of country coordination mechanisms operational, supporting implementation of long-term national plans to expand DOTS

Indicator	Baseline	Target	Achievement
Number of the 22 high-burden countries with functional national partnerships and plans	15/22	22/22	21/22

National interagency coordinating mechanisms and plans are in place and during the biennium work was carried out towards the establishment of country-level Stop TB partnerships. At the end of the biennium WHO regional offices were also working with 87 targeted countries (in addition to the high-burden countries) on plans and coordination mechanisms within their national health planning frameworks.

Global TB Drug Facility maintained, with expanded access to treatment and cure

Indicator	Baseline	Target	Achievement
Additional number of patients treated with support from the Global TB Drug Facility via grants and direct procurement services	Not established	4 million patients provided with anti-tuberculosis drugs	4.29 million patient treatments provided via the Facility

The Global TB Drug Facility expanded its direct procurement services substantially and more than six million patient treatments have been provided in 70 countries, since the Facility was established.

Political commitment sustained and mobilization of adequate resources ensured through nurturing of the Stop TB Partnership and effective communication of the concept, strategy and progress of the Global Plan to Stop TB

Indicator	Baseline	Target	Achievement
Proportion of countries with agreed national strategy for stopping tuberculosis with supporting advocacy	22 countries	39 countries	39 countries
International financial resources available for tuberculosis control activities in 22 high-burden countries	US$ 141 million (2003)	No targets set	US$ 148 million (2004) US$ 194 million (2005)
Number of additional partners for tuberculosis control	330 partners	400 partners	438 partners

Increases in domestic and international funding meant that financing for tuberculosis control, in the 22 countries with the highest tuberculosis burden, increased from just over US$ 900 million in 2004 to US$ 1200 million in 2005. It is projected to reach US$ 1400 million in 2006. The well-established Stop TB Partnership facilitated increased coordination of advocacy and resource mobilization worldwide, especially through its first Global Plan to Stop TB 2001-2005, the partners' forum held in New Delhi in 2004, seven working groups, and the development of the second Global Plan to Stop TB 2006-2015.

[1] Most recent data available. 2007 global tuberculosis control report will report on 2005 target achievement.

Global surveillance and evaluation systems maintained and expanded to monitor progress towards global targets, specific resource allocations for tuberculosis control, and impact of control efforts

Indicator	Baseline	Target	Achievement
Percentage of countries submitting annual surveillance, planning and financial reports for inclusion in the annual global tuberculosis control report	Surveillance 94% Financial data 64%	Not established	Surveillance 95% Financial data 66%

Eleven consecutive years of data (1994-2004) are now available to assess progress towards the global tuberculosis control targets. In 2005, financial reports were received from countries accounting for 91% of the estimated global tuberculosis burden. The quantity and quality of financial data have continued to improve.

New policies and strategies to tackle multidrug resistance and to improve tuberculosis control in countries with high HIV prevalence formulated

Indicator	Baseline	Target	Achievement
Proportion of targeted countries implementing combined interventions between national tuberculosis and AIDS control programmes	8	15	19 countries have a national policy for providing HIV testing and counselling to tuberculosis patients, and 23 have a policy for screening people living with HIV/AIDS for tuberculosis
Proportion of targeted countries implementing DOTS revised to cope with multidrug-resistant disease	15	30	The Green Light Committee approved sound multidrug-resistant tuberculosis control programmes in 30 countries for almost 13 000 such patients
Proportion of all countries surveying drug resistance	77	90	Drug resistance surveillance data available from 90 countries and trends from 26 countries

There has been a significant increase in the number of coinfected patients accessing joint services; a tenfold increase in the number of people living with HIV/AIDS screened for tuberculosis and a fourfold increase in the number of tuberculosis patients receiving HIV counselling and testing. Increased financing is now making it possible to scale-up collaborative tuberculosis/HIV activities. The biennium saw a major increase in multidrug-resistant tuberculosis surveillance and control efforts in resource-limited countries. Guidelines on the programmatic management of drug-resistant tuberculosis were developed, guidelines on drug resistance surveillance revised, multidrug-resistant tuberculosis control included in the new Stop TB Strategy, capacity building in multidrug-resistant tuberculosis management and technical support expanded, more financial resources made available for country-level efforts, and the feasibility and cost-effectiveness of multidrug-resistant tuberculosis control positively evaluated. Implementation plans were developed, including for the three countries carrying 68% of the global multidrug-resistant tuberculosis burden: China, India and Russian Federation; and a 10-year strategic plan was developed.

New policies and strategies formulated to increase case detection and cure rates through engagement of all governmental care providers, local nongovernmental organizations, community care workers and private practitioners, as well as through integrated respiratory care at primary level

Indicator	Baseline	Target	Achievement
Proportion of targeted countries able to expand tuberculosis care in all governmental services and through local nongovernmental organizations operating in the poorest areas	20 countries	40 countries	100% (40 countries)
Proportion of targeted countries implementing private-public mix and community care interventions	9 countries	20 countries	100% (20 countries)

Proportion of targeted countries (with adequate health systems) implementing integrated respiratory care at primary level	12 countries	10 additional countries	20 countries 80% (8 additional countries)

During 2004-2005, there was a dramatic acceleration in extending the capacity to deliver DOTS services in health facilities directly under the scope of national tuberculosis programmes. However, many more patients need to be reached over and above such services, and innovative strategies to improve case detection were pursued. While the focus in Africa was on expanding community tuberculosis care services, in Asia the principal effort was directed at engaging diverse public and private care providers, including local nongovernmental organizations. The activities concerned also received a boost thanks to the availability of grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria. Notable progress was made, for example, in China, India, Indonesia, Kenya, Myanmar and the Philippines in expanding public-public and public-private mix initiatives. Integrated respiratory care at primary care level through the Practical Approach to Lung Health strategy is being initiated and extended in 20 countries. Five of these countries have adopted the strategy as national policy and are implementing it across national health services.

Success factors and impediments

Success factors

- Increased global advocacy and interest in tuberculosis.
- Momentum and enthusiasm to advance towards global targets, clear strategies and plans to support accelerated implementation on a national scale, along with increased resources.
- Coordination of technical and financial partners at country, regional and global levels through WHO and the Stop TB Partnership.
- Joint planning across all WHO offices with intensified support to countries in planning, monitoring and evaluation.

Impediments

- Limited unspecified voluntary resources limit WHO's capacity to respond rapidly to Member States' and donors' requests for rapid policy development, technical cooperation and monitoring/evaluation.
- Health systems weaknesses and bottlenecks to implementation resulted from the following: limited human resources at all levels, insufficient financing flows for implementation, lack of laboratory capacity, unmet national commitments to effect rapid scale-up of joint tuberculosis/HIV efforts, insufficient capacity to respond to requests at country level for provision of technical assistance or monitoring and evaluation.

Lessons learnt in 2004-2005 and how they will be applied in 2006-2007

- Investment in capacity building for technical assistance to leverage use of new resources for disease control is critical to ensuring development of plans, implementation capacity, problem-solving, local innovation and impact analysis.
- In 2006-2007, WHO must be more closely linked with technical partners in a structured network to ensure maximum responsiveness to Member States' and others' needs; the Organization is therefore working closely with donors, through the Global Plan to Stop TB 2006-2015, to close technical assistance financing gaps.
- Consolidation of effective new approaches under the new Stop TB Strategy should permit faster and more coherent joint scale-up of approaches, engagement of partners, especially affected persons and communities, as well as the full range of health providers needed to expand access to tuberculosis treatment so as to ensure safe and effective care and reach global targets.
- The 2006-2007 work programme for this area of work is fully oriented towards the scale-up of this integrated new strategy, building on WHO policies and Member States' experience and innovation. This is also the case for the Global Plan to Stop TB 2006-2015, regional planning and pathfinder plans of high-burden countries. Furthermore, the strategy is informing collaboration with other areas of work and medium-term planning.
- Active engagement with other partners and partnerships to strengthen health systems, mobilize resources, align approaches within larger development frameworks and harmonize implementation support and sharing of best practices will all be critical to meeting 2015 targets.

- In 2006-2007 further advances can be made by using WHO's global, regional and country networks and taskforces, working groups of the Stop TB Partnership, and forums and partnerships working to attain other health-related Millennium Development Goals, as well as applying best practice principles.

Approved budget and actual expenditure

		Approved budget	Actual expenditure		
			Regular budget	Other sources	All funds
Total 2004-2005 (US$ thousand)		124 531	13 027	139 465	152 492
Percentage	countries	64	52	40	41
	regions	14	30	12	14
	global	22	18	48	45

SURVEILLANCE, PREVENTION AND MANAGEMENT OF NONCOMMUNICABLE DISEASES

WHO objective(s)

To ensure that governments are better equipped technically and institutionally to reduce people's exposure to the major risk factors and that health systems are prepared to deal with the rising burden of chronic conditions, and to promote standards of health care for people with noncommunicable diseases.

Indicator(s) and achievement

Number of countries adopting prevention and control policies on noncommunicable diseases.

Number of demonstration sites on prevention and control of noncommunicable diseases.

Number of global and regional networks supporting implementation of programme. Seventy-six countries participated in six regional networks and have either national integrated noncommunicable disease prevention programmes or local demonstration projects. The fourth meeting of the Global Forum on Chronic Disease Prevention and Control held on 3-6 November 2004 in Ottawa, was attended by 14 delegates from six regional networks. Each regional network supports the implementation of national noncommunicable disease prevention and control programmes.

Main achievements

- The case for urgent action to halt and turn back the growing threat of chronic diseases was made in a WHO report[1] published in October 2005.
- In response to increasing deaths attributable to noncommunicable diseases, and in recognition of the evidence identifying preventable risk factors, the Global strategy on diet, physical activity and health was adopted by the Health Assembly in 2004.[2]
- The diabetes awareness campaign, Diabetes Action Now, established during the last biennium provided the basis for supporting development of national policies in low- and middle-income countries.
- Surveillance systems for chronic disease risk factors are being established in an increasing number of developing countries. The well-established stepwise approach to such surveillance has been implemented in 23 of the 47 targeted countries since 2001, and 71 countries have received training in the use of the tool. Among other important surveillance systems to have been developed are the stepwise approach to stroke surveillance and youth risk behaviour surveillance.
- The adoption of resolution WHA58.22 on cancer prevention and control by the Health Assembly in May 2005 has led to intensified action on cancer. The WHO Cancer Advisory Committee to the Director-General and the cancer technical group for the development of a cancer control strategy have been established. Guidelines for cancer prevention and control are also under development, and an alliance of cancer control parties is being established.
- A global alliance against chronic respiratory diseases composed of international organizations, institutions and agencies from developed and developing countries with the common goal of fighting chronic respiratory diseases was established in 2005.
- Work on the establishment of a global initiative for the management of chronic diseases has begun with strong support from the Regional Office for the Eastern Mediterranean.
- For the first time, a significant decline in the global visual impairment burden has been observed (from 45 million to 37 million disability-adjusted life years worldwide) due mainly to the falling trend in communicable diseases such as trachoma and onchocerciasis and the growing number of blindness prevention programmes worldwide.
- Considerable progress has been made in the regions in adapting and implementing evidence-based guidelines for chronic diseases. The success of the implementation in the Western Pacific Region of a stepwise intervention planning framework for noncommunicable diseases is offering a model that promises to be a best practice example for implementation in other regions. This framework has already been adapted and disseminated as a report[1] and in the associated series in the *Lancet*.

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

[2] Resolution WHA57.17.

Illustration of selected achievements

- The success of the noncommunicable diseases intervention framework implemented in Viet Nam has provided a model for prevention and control that could be replicated in other countries. It has also provided a practical demonstration of the stepwise framework recommended in the global report.[1] This framework is being proposed to health ministries as a basis for a policy and regulatory environment in which other sectors can operate successfully. The guidance and recommendations provided are for use by all stakeholders, national and subnational level policy makers and planners, as well as individuals.

Achievement of Organization-wide expected results

WHO surveillance framework, standardized methods and materials for simplified surveillance systems for noncommunicable diseases in order to inform policy and programmes widely adopted in countries and regions

Indicator	Baseline	Target	Achievement
Percentage of countries within each region that have conducted a training workshop on the WHO stepwise approach to risk factor surveillance	5% (in the African, South-East Asia, Eastern Mediterranean and Western Pacific regions)	30% in the four targeted regions	67% (71 countries in the 4 targeted regions attended planning and coordination and/or data management workshops)
Percentage of countries within each region that have successfully implemented the stepwise approach	0% (in the African, South-East Asia, Eastern Mediterranean and Western Pacific regions)	20% (21countries in the four targeted regions)	22% (23 countries at different stages of stepwise approach implementation)

Capacity building in the planning and data management aspects of surveillance has been provided to 71 countries at four regional training workshops and more than eight national training workshops on the WHO stepwise approach in the various regions. During the biennium, 23 countries either fully implemented the stepwise approach to chronic disease risk factor surveillance or reached the final phase of implementation. A manual was updated and disseminated to five regions to provide a complete overview and guidance to sites wishing to implement the stepwise approach to chronic disease risk factor surveillance. Data entry and data analysis tools were also developed and disseminated to sites to support them in strengthening surveillance activities and implementing health promotion policies. Another manual on the stepwise approach to stroke surveillance was developed in response to the need for improvements in stroke data collection, prevention and treatment. It aims to provide data for Member States and will form a framework for surveillance and data collection. The feasibility study was completed at the end of the biennium and countries and sites are now invited to take part in the project. A second edition of the Surveillance of Risk Factors report series was issued in May 2005. It describes the status of country-level chronic noncommunicable disease risk factors and their contribution to the burden of chronic diseases in populations, and provides essential statistics for planning and implementing health policies in all countries. It is based on an online tool, the WHO Global InfoBase, which provides accessible, traceable and transparent information on chronic disease risk factors and mortality from chronic diseases at the country level.

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

National integrated prevention and control programmes for noncommunicable diseases established, including community-based demonstration projects, health promotion, health services and national policy development, and linked by strengthened regional networks and the global forum for prevention and control of such diseases

Indicator	Baseline	Target	Achievement
Number of countries participating in each regional network	45 countries participated in regional networks: Countrywide Integrated Noncommunicable Diseases Intervention network (CINDI): 27; network for the Conjunto de Acciones para Reduccion Multifactorial de Enfermedades No Transmisibles (CARMEN): 5; Eastern Mediterranean Approach to Noncommunicable Diseases network (EMAN): 6; Network of African Noncommunicable Diseases Interventions (NANDI): 7	Increase in number of countries participating in regional networks	76 countries participating in networks: Countrywide Integrated Noncommunicable Diseases Intervention network (CINDI): 31; network for the Conjunto de Acciones para Reduccion Multifactorial de Enfermedades No Transmisibles (CARMEN): 14; Eastern Mediterranean Approach to Noncommunicable Diseases network (EMAN): 6; Noncommunicable Diseases Interventions (NANDI): 9; South-East Asia network for noncommunicable diseases prevention (SEANET): 8; Western Pacific Region noncommunicable diseases network (MOANA): 8
Number of countries in the networks with specific national demonstration programmes	27 countries with national demonstration programmes	Increase in number of countries with national demonstration programmes worldwide	More than 40 countries have national demonstration projects
Proportion of targeted countries initiating model projects	No specific countries targeted	Increase in number of model projects initiated by countries participating in networks	45% of countries participating in regional networks initiated model projects. 34 countries established model projects. Countries participating in the networks either have national integrated noncommunicable diseases prevention programmes or local demonstration projects

All WHO regions have established networks. Countries participating in networks increased in number from 45 to 76 during the biennium. Thirty-one countries participate in the Countrywide Integrated Noncommunicable Diseases Intervention network (CINDI) in the European Region, 14 in the Conjunto de Acciones para Reduccion Multifactorial de Enfermedades No Transmisibles network (set of actions for the multifactorial reduction of noncommunicable diseases, otherwise known as CARMEN) in the Region of the Americas, six in the Eastern Mediterranean Approach to Noncommunicable Diseases network (EMAN), nine in the Network of African Noncommunicable Diseases Interventions (NANDI), eight in South-East Asia network for noncommunicable diseases prevention (SEANET), and eight in the Western Pacific Region noncommunicable diseases network (MOANA). National demonstration projects increased throughout the regions. The fourth meeting of the Global Forum on Chronic Disease Prevention and Control held on 3-6 November 2004 in Ottawa, was attended by 14 delegates

from six regional networks. Representatives from international nongovernmental organizations, the World Bank, FAO and WHO were also in attendance.

Multisectoral strategies and plans of action on diet and physical activity adopted

Indicator	Baseline	Target	Achievement
Proportion of targeted regions and countries with multisectoral strategies and plans on diet and physical activity	Not established	Not established	In the European Region 44 Member States (84%) have either adopted, developed but not yet adopted or have a nutrition policy document under preparation. 29 Member States (55%) have adopted their national nutrition policy document. In the South-East Asia Region 4 Member States (35%) have developed or are in the process of developing multisectoral strategies and plans on diet and physical activity

Although no country in the Western Pacific Region has multisectoral strategies and plans on diet and physical activity, much of this work is already being done under different guises: more than 80% of Western Pacific Region Member States have at least one of the following: an integrated noncommunicable diseases plan; a nutrition plan of action; or a physical activity policy. Progress on the implementation of the Global strategy on diet, physical activity and health has been slow, primarily owing to resource constraints. Nevertheless, progress has been made in all regions and several Member States' plans have been developed. Regional workshops have been held in the Regional Offices for Africa and South-East Asia to discuss regional approaches to implementation and similar workshops are planned for the WHO Regional Office of the Americas/PAHO and the Regional Office for the Western Pacific in 2006. The Regional Office for Europe has focused on the development of a European noncommunicable diseases strategy and preparations for a Ministerial Conference on counteracting obesity to be held in Istanbul, Turkey on 15-17 November 2006. Discussions are ongoing in the Regional Office for the Eastern Mediterranean. Considerable progress has also been made by the food and non-alcoholic beverages industries in responding to the public health problems caused by unhealthy diets and physical inactivity.

Comprehensive policies and strategies adopted by regions and countries in order to strengthen the capability of health systems to deal with chronic conditions, to enhance adherence to therapies and behaviours and to reinforce long-term care

Indicator	Baseline	Target	Achievement
Proportion of targeted countries adopting policies on improving care for chronic conditions	0%	6	8 Member States (133%) adopted policies on improving care for chronic conditions: 4 in the South-East Asia Region and 4 in the Western Pacific Region
Proportion of targeted countries adopting strategies for enhancing adherence to long-term therapies	0%	6	4 Member States (67%) in the Western Pacific Region No further information available as project was suspended at headquarters level
Number of countries with a health care system better adapted to prevention	0	6	14 Member States (5 in the South-East Asia Region and 9 in the Western Pacific Region)

Health system development for chronic disease management mainly involved the development and implementation of comprehensive strategies for several different levels of intervention. In the Eastern Mediterranean Office, support to develop an integrated comprehensive policy and strategic framework for the prevention and control of noncommunicable diseases in primary health care was given to 12 countries. Two countries also launched national cervical cancer screening programmes. In the South-East Asia Region, policies for improving care for chronic conditions were adopted in India, Indonesia, Maldives and Thailand. The affordability and availability of essential medicines for major chronic diseases was also assessed in three countries. In the Western Pacific Region, progress was made largely in the development of clinical management guidelines that span the three indicators in Cook Islands, Mongolia, Philippines and Viet Nam. In headquarters, policies to tackle barriers to secondary prevention and the treatment of cardiovascular disease were assessed in 12 countries and strategies to address gaps were implemented in eight Member States (Brazil, Indonesia, Islamic Republic of Iran, Pakistan, Russian Federation, Sri Lanka,

Tunisia and Turkey) in five regions. Twelve Member States from five regions (namely, demonstration sites in Bangladesh, Chile, China, India, Indonesia, Kenya, Malawi, Mozambique, Nigeria, Pakistan, Sri Lanka and Tunisia) have adopted the WHO cardiovascular disease risk management package to strengthen the capacity of health systems to deal with cardiovascular disease and their risk factors, with encouragement from WHO.

Secondary prevention and clinical preventive and treatment interventions identified; evidence-based guidelines disseminated for management of cancer, diabetes, cardiovascular diseases and chronic respiratory disease; and guiding principles available for integrating genetic services into health care

Indicator	Baseline	Target	Achievement
Number of countries implementing recommended WHO guidelines on main noncommunicable diseases	Not established	Not established	All regions reported implementation of WHO guidelines at country level for noncommunicable diseases
Number of countries with an expanded array of clinical preventive services being financed	Not established	Not established	1 Member State, Maldives, is financing clinical preventive services for thalassaemia. Cape Verde, Russian Federation and Tunisia are financing clinical preventive services for chronic respiratory disease
Proportion of targeted countries integrating genetic services into health care	11	20	100% (all 20 target countries) integrated genetic services into health care

Member States implementing recommended WHO guidelines on chronic respiratory disease are: Costa Rica, Cuba, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, and Panama. Six Member States: Indonesia, Islamic Republic of Iran, Pakistan, Sri Lanka, Tunisia and Turkey implemented WHO guidelines on secondary prevention of cardiovascular disease. Fifteen countries in the Eastern Mediterranean Region implemented WHO guidelines on the main noncommunicable diseases. In the African Region, guidelines on diabetes control were reviewed at a WHO/International Diabetes Federation meeting of French-speaking African countries. In the Eastern Mediterranean Region, country implementation at primary health care level of six newly developed interventional noncommunicable diseases guidelines (on the prevention and care of hypertension, diabetes, dyslipidaemia, breast and lung cancer and rheumatic fever) is ongoing but is proving difficult due to a lack of resources for training. In the European Region, guiding documents on secondary prevention and improving the quality of life of people with cardiovascular disease were prepared. Guidelines on acute stroke care and a therapeutic reduction in the number of patients with coronary heart disease were also developed. The draft preliminary report of the global survey on assessing the progress in national chronic diseases prevention and control showed that the proportion of Member States with national guidelines on the management of chronic diseases has increased by about 17% since the past biennium. In the South-East Asia Region, all Member States are applying available WHO guidelines, and new guidelines on the management of diabetes, asthma and chronic obstructive pulmonary disease are being developed in India. In the Western Pacific Region, new guidelines on diabetes and/or hypertension have been developed in Cook Islands, Mongolia, Philippines and Viet Nam. At headquarters, integrated guidelines based on the absolute risk approach for the prevention of cardiovascular disease and risk prediction charts for all regions were developed. The internet-based Genomic Resource Centre received 100 000 visits from 100 countries in 2005. A surveillance database on congenital malformation and haemoglobin disorders was initiated. Pilot projects were launched in selected countries to assess the health burden of congenital and genetic disorders and their control in primary health care. Practical guidelines on integrated national programmes for chronic diseases are still under development in association with regional offices.

Strategies for prevention and control of blindness, deafness and hearing impairments developed, and countries supported in their implementation; burden of visual and hearing impairment, and programme implementation regularly monitored

Indicator	Baseline	Target	Achievement
Proportion of targeted countries documenting adequately the burden of visual and hearing impairments	Not established	Not established	50% of Member States (96 countries) adequately documented visual impairment. 5% of Member States (9 countries) adequately documented hearing impairment

Indicator	Baseline	Target	Achievement
Number of countries adopting and implementing WHO strategies on blindness and deafness	33 countries adopting WHO strategies on blindness	120 low and middle-income countries adopting WHO strategies on blindness by the end of 2006 as set out in resolution WHA56.26	65 countries adopting WHO strategies on blindness
	No countries adopting WHO strategies on deafness	5 countries adopting WHO strategies on deafness	3 countries adopting WHO strategies on deafness

VISION 2020 global initiative national workshops were held in 131 countries with national plans, of which 65 had already implemented them. The trachoma control strategy was implemented in 36 countries with various levels of coverage. Community-directed treatment for onchocerciasis was provided to 45 million people. Child-friendly eye care centres were established in 30 countries and operational research conducted in Brazil, China, India and South Africa was supported by a variety of donors. Prevalence and causes of hearing impairment surveys were conducted in Madagascar and initiated in four provinces in China. The Primary Ear and Hearing Care training resource was piloted in India and Nigeria and the WHO Guidelines on Hearing Aids and Services for Developing Countries, were published. Workshops on the provision of affordable hearing aids were held at headquarters and a new independent partnership, WWHearing – World Wide Hearing Care for Developing Countries, was created to provide affordable hearing aids and services for developing countries. Pilot studies on the provision of affordable hearing aids and services were conducted in Brazil, China and South Africa are being initiated in India.

Success factors and impediments

Success factors

- Political commitment to provide adequate financial resources at project inception.
- Identification of committed programme focal points at health ministry level and in national coalitions.
- Consensus on priorities through frequent interaction and good collaboration with WHO representatives in joint planning and implementation of Programme budget, and with collaborating centres and centres of excellence.
- Selection of priority countries based on clear criteria.
- Mutual trust, consistency of approach, enhanced uniformity and efficiencies resulting from development of stepwise intervention model, and provision of strengthened support to national counterparts.
- Good coalition building with all players, including civil society, for joint planning and implementation; strong network and health ministry support.
- Increased capacity at country level through provision of training in the stepwise approach to chronic disease risk factor surveillance and data management and analysis.
- Existence of flexible tools and frameworks using a stepwise/modular approach.

Impediments

- Insufficient resources (including human resources) to tackle the rapidly rising disease burden, with noncommunicable diseases regarded as a relatively low priority by many governments, international organizations and donors. This hampers the implementation of noncommunicable diseases guidelines and often results in a lack of capacity to go beyond demonstration projects.
- Limited budget allocations for the Programme for the Prevention of Blindness and Deafness in all regions; at headquarters, a high level of voluntary contributions (one-third of total voluntary contributions in noncommunicable diseases budget allocation) gives the impression that noncommunicable diseases budget allocations at headquarters level are adequate.
- Difficulty of developing effective processes for the integration and use of evidence-based guidelines within national health services, even though new models such as the Western Pacific Region's evidence-based conceptual framework for a stepwise approach to noncommunicable surveillance are showing promising and encouraging results for adaptation in other settings.

Lessons learnt in 2004-2005 and how they will be applied in 2006-2007

- Better advocacy and resource mobilization to raise the status of noncommunicable diseases requires further effort. Data on the socioeconomic impact of noncommunicable diseases and risk factors are particularly important and must be given heightened attention in advocacy efforts.
- In the Western Pacific Region, the evidence-based conceptual framework for a stepwise approach to noncommunicable disease surveillance was recommended by the regional programme review as an example of a formal conceptual framework that deserves wider dissemination. Consequently, the concept is being incorporated into all chronic diseases and health promotion plans and technical advice to Member States in 2006-2007.
- Supporting countries to generate and use their own evidence in the development of noncommunicable diseases prevention and control programmes is crucial to success.
- Further elaboration of a strategic plan with regional offices, and further involvement of regional advisers in noncommunicable diseases activities to build capacity at regional office level and promote work that it has not been possible to pursue directly with countries is a priority. Annual consultations between the three levels of the Organization should be held to strengthen links and coordinate action.
- While disease-specific guidelines are available, it is necessary to develop integrated guidelines across all noncommunicable diseases. Therefore, the focus in 2006-2007 should be on strengthening health systems for noncommunicable diseases rather than concentrating on guidelines for specific diseases.

Approved budget and actual expenditure

		Approved budget	Actual expenditure		
			Regular budget	Other sources	All funds
Total 2004-2005 (US$ thousand)		37 480	22 802	18 553	41 355
Percentage	countries	30	41	3	24
	regions	26	24	26	25
	global	44	35	71	51

TOBACCO

WHO objective(s)

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

Indicator(s) and achievement

Number of countries that ratify the Framework Convention on Tobacco Control. A total of 115 Member States had become Contracting Parties to the Convention by 31 December 2005.

Number of countries with effective tobacco-control plans and policies that take account of the provisions of the Convention. It is estimated that 40 Member States have effective tobacco-control plans and policies that take into account the Convention's provisions.

Main achievements

- The WHO Framework Convention on Tobacco Control entered into force on 27 February 2005.
- Seventeen awareness-raising and capacity-building workshops were held during the 2004-2005 biennium, in which at least 110 countries took part. These workshops contributed to the momentum for ratification of the Convention which became the most widely embraced United Nations treaty.
- WHO, providing interim treaty secretariat functions, convened two Intergovernmental Working Groups, as mandated by resolution WHA56.1. The Working Group considered and prepared proposals on those issues identified in the Convention for consideration and adoption by the Conference of the Parties at its first session in February 2006. Documentation on substantive issues was prepared.
- By December 2005, 30 best practice reports had been published and disseminated as part of the "success stories and lessons learnt" series and most are available on the WHO web site.
- A key capacity-building publication was disseminated widely, and used in national capacity-building workshops and is being translated into the other official United Nations languages and Japanese.[1]
- World No Tobacco Day 2004 was celebrated across all regions and raised awareness of the negative economic impact of tobacco use on individuals, households and national economies. World No Tobacco Day 2005 successfully elicited the active engagement of health professional associations worldwide, and benefited from follow-up on initiatives such as the promotion of the code of practice on tobacco control for health professional associations and the completion of the first Global Health Professionals Survey.
- The publication of a study on the Millennium Development Goals and tobacco control[2] established tobacco control as a development issue by mapping out the relationship between tobacco and the eight Millennium Development Goals.
- At its first meeting in Montebello, Canada in October 2004 the WHO Study Group on Tobacco Product Regulation adopted a recommendation on guiding principles for the development of tobacco product research and testing capacity and proposed protocols for the initiation of tobacco product testing. In 2005, the Study Group issued an advisory note on waterpipe tobacco smoking,[3] as well as a best practice report on the regulation of tobacco products in Canada.[4]
- The WHO Tobacco Laboratory Network was established in early 2005. It is a global network of government, university and independent laboratories to test and conduct research on the contents and emissions of tobacco products in accordance with the Convention. WHO coordinates the Network and acts as its secretariat.
- The sixth session of the United Nations Ad Hoc Interagency Task Force on Tobacco Control was held on 30 November - 1 December 2005 at ILO headquarters in Geneva.

[1] *Building blocks for tobacco control: a handbook.* Geneva, World Health Organization, 2004.

[2] *Millennium Development Goals and Tobacco Control: An opportunity for global partnership.* Geneva, World Health Organization, 2004.

[3] *Waterpipe Tobacco Smoking: Health Effects, Research Needs and Recommended Actions by Regulators.* Geneva, World Health Organization, 2005.

[4] *Best practices in tobacco control: regulation of tobacco products: Canada report.* Geneva, World Health Organization, 2005.

Illustration of selected achievements

In the Western Pacific Region all Member States have signed or acceded to the Convention and 25 out of 27 have become Parties. China has made rapid progress with tobacco control through the strategic use of the limited resources available to elicit government attention and action at all levels of WHO.

Achievement of Organization-wide expected results

Number of Member States with comprehensive tobacco-control policies and national plans of action increased

Indicator	Baseline	Target	Achievement
Number of Member States that have adopted legislation or its equivalent in the following areas: 1. Ban on smoking in health care and educational facilities (FCTC Article 8). 2. Ban on direct advertising of tobacco products in national media (TV, radio, newspapers) (FCTC Article 13). 3. Health warnings on tobacco products which meet the criteria set forth in FCTC Article 11	16	30	40

The new component on national legislation in the European Region's comprehensive database on tobacco-control has encouraged the reviewing and updating of existing laws. In the Region of the Americas, the Pan American tobacco information online system database has also informed national policies on tobacco control. Across the regions, capacity building has been a decisive element in reinforcing or creating new tobacco control legislation.

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

Indicator	Baseline	Target	Achievement
Number of best practices published by WHO in tobacco control focusing on educational, legislative, economic and environmental aspects and regulatory mechanisms	15	35	29
Number of new projects initiated under the umbrella of the United Nations Ad Hoc Interagency Task Force on Tobacco Control	6	9	9
Number of Globalink members worldwide	4000	4500	5117

In order to continue effective implementation of the Convention, there must be multisectoral collaboration on tobacco-control, with emphasis on the development of strategies to address its social and economic implications. Towards this end, the sixth session of the United Nations Ad Hoc Interagency Task Force on Tobacco Control was convened in 2005. The subjects discussed included smoke-free workplaces, illicit trade in tobacco products, the link between tobacco control and economic development, and issues relating to preparations for implementation of the Convention in Member States. Its decisions outline the principal themes for the fourth report to the United Nations Economic and Social Council. The United Nations Interagency Task Force is represented by a group of United Nations agencies and external organizations, including ILO, FAO, the World Bank, UNHCR, the World Customs Organization, the European Law Enforcement Organization, the European Commission, the European Anti-fraud Office, UNICEF and UNESCO, with WHO acting as the secretariat.

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

Indicator	Baseline	Target	Achievement
Number of countries that completed the Global Youth Tobacco Survey at least once	112	160	164
Number of countries that have completed the Global Youth Tobacco Survey at least twice	11	30	50
Number of countries covered by the Global Information System on Tobacco Control	0	74	154

By December 2005, the first Global Youth Tobacco Survey had been completed in 164 countries. The second was conducted in more than 50 countries. Regional programme and policy workshops are being organized to link the data collected from this survey to action in Member States. The Global Health Professional Survey was initiated during the biennium and pilot studies were conducted in 10 countries. Plans to extend the Survey to about 30 countries were in progress by December 2005.

All the regional databases and surveys have contributed towards gathering data on many different tobacco-related aspects at national and regional levels. In many cases, this information has informed the development of new action plans or adjustment of existing ones.

Accelerated integration of strategies for tobacco control into public health programmes

Indicator	Baseline	Target	Achievement
Number of WHO programmes and areas of work that integrate tobacco control into their programmes	6	10	10

During the biennium, collaboration between WHO departments was strengthened to accelerate integration of tobacco control strategies into public health programmes. The target for the biennium was achieved with four new collaborative initiatives in tuberculosis, cancer control and prevention, health statistics and evidence, and environmental health. The regional offices have also reported integration initiatives. The systematic and sustained integration of tobacco control strategies into other areas of work at all levels of the Organization remains a challenge. Commitment from national governments will be crucial for the integration of tobacco control into national public health programmes.

Greater awareness and understanding globally of the increased use of tobacco and its consequences through stronger media coverage and information systems, and decreased social acceptability of tobacco use

Indicator	Baseline	Target	Achievement
Number of countries that have local nongovernmental organizations and/or civil-society bodies undertaking media/education campaigns on the harmful effects of tobacco use	25	40	112
Average number of newswires that distribute tobacco-control news on a daily basis	3	5	5

Wide media coverage of the Convention and World No Tobacco Day increased awareness of tobacco control in many countries. The World No Tobacco Day themes of poverty and the role of health professionals proved to be effective.

Increased transparency, public knowledge and regulation of tobacco-industry activities

Indicator	Baseline	Target	Achievement
Number of published results of country-specific research on tobacco-industry activities	12	18	26

WHO continues to fulfil its mandate to monitor tobacco industry activities. Research is also being carried out on tobacco industry activities worldwide. The information is compiled in a monthly report for use by headquarters and regional staff and for sharing with relevant tobacco control partners. Vigilant monitoring of the industry is crucial as it continues to undermine tobacco control efforts through increased lobbying, sponsorship and advertising activities in susceptible Member States.

Entry into force of the WHO Framework Convention on Tobacco Control, and adoption of initial protocols

Indicator	Baseline	Target	Achievement
Number of countries that ratify the convention	5	40	115

By the end of the biennium there were 115 Contracting Parties to the Convention, plus the European Community, of which 110 Member States plus the European Community, had ratified it. The successful outcome was due partly to the numerous awareness-raising and capacity-building workshops organized jointly by headquarters and the regional and country offices. At its two sessions in June and December 2004, the Intergovernmental Working Group prepared numerous recommendations for submission to the Conference of the Parties at its first session in February 2006.

Success factors and impediments

Success factors

- Strengthened collaboration between headquarters, regional and country offices for better support to tobacco control activities.
- Rapid entry into force of the Convention and steady increase in number of countries ratifying it.
- Increased resources for tobacco control and country offices.
- Good coordination between governments and nongovernmental organizations in the Member States leading the tobacco-control agenda.

Impediments

- Need for political will by governments and funding commitment by donors to support tobacco control implementation in Member States.
- Major differences between national legislation mechanisms.
- Inadequate awareness among public and policy-makers of industry tactics and, in many cases, unsatisfactory coordination among relevant sectors.
- Despite the increase in financial and human resources they are still inadequate to allow all the goals to be tackled effectively.
- The limited capacity of ministries of health in many Member States to design and apply effective tobacco control policies.

Lessons learnt in 2004-2005 and how they will be applied in 2006-2007

- Awareness of the harm caused by tobacco use and exposure to tobacco smoke needs to be increased in Contracting and non-Contracting Party Member States through advocacy and media campaigns.
- Stronger support for the development of national tobacco control legislation is required at all levels.
- Assistance must continue to be provided at all levels to those Member States that have not yet become Contracting Parties to the Convention to maintain momentum.
- Developing countries continue to request technical and financial assistance to enable them to implement the Convention. Resources should therefore be sought and deployed at global, regional, and national levels.
- As a reaffirmation of its confidence in WHO's technical capacity and leadership, the Conference of the Parties, at its first session, decided to establish the Convention secretariat within WHO. It also recommend that the Health Assembly continue to support and strengthen implementation of the Convention.

Approved budget and actual expenditure

		Approved budget	Actual expenditure		
			Regular budget	Other sources	All funds
Total 2004-2005 (US$ thousand)		20 483	8 812	8 903	17 715
Percentage	countries	28	22	8	15
	regions	39	37	47	42
	global	33	41	45	43

HEALTH PROMOTION

WHO objective(s)

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

Indicator(s) and achievement

- *Production and dissemination of evidence of effective health promotion.* 25 projects demonstrating the effectiveness of health promotion, particularly in low- and middle-income countries, were initiated and disseminated in technical meetings, international conferences and journals.
- *Increase in institutional capacity to promote health in Member States.* Data to identify action areas and monitor progress for building institutional capacity of health ministries were collected from 140 countries. All six regions demonstrated progress in providing evidence of the effectiveness of health promotion and translating evidence into practice.
- *Formulation of healthy public policies.* Finalization of the Bangkok Charter for Health Promotion in a Globalized World in August 2005 demonstrated the global commitment to addressing health inequalities worldwide by tackling the underlying social determinants of poor health.
- *Improvement in health of marginalized groups.* The prison health project network increased from 18 to 28 countries in 2004. The Healthy Municipalities and Communities initiative was developed in seven low-income countries of the Region of the Americas.

Main achievements

- The Bangkok Charter for Health Promotion in a Globalized World demonstrated the global commitment to addressing health inequalities. The 6th Global Conference on Health Promotion (Bangkok, 7-11 August 2005) was attended by some 650 participants from more than 100 countries.
- More than 140 countries contributed to the first stage of the capacity-mapping project. Findings will be used to further develop health promotion capacity-building work and enable action areas to be identified and progress reported.
- Member States in all regions received support in developing health promotion policies and action plans, including data on oral health.
- Excellent progress was made in collecting health data in schools, including data on oral health.
- Collaboration was further strengthened within WHO and between WHO and other key stakeholders, including nongovernmental organizations, WHO collaborating centres, the International Union for Health Promotion and Education, and United Nations organizations.

Illustration of selected achievements

The Regional Office for Africa contributed to building national capacity for health promotion by inducting multisectoral teams to develop and manage health promotion activities and programmes. Participatory approaches were used to train the teams that in turn trained additional actors in streamlining health promotion in national and lower-level programmes. Cameroon, Kenya, Lesotho, Niger and Rwanda used the skills acquired to improve the health promotion component in national and local programmes. In Lesotho, comprehensive HIV-prevention and AIDS-support activities for youth benefited from multisectoral programming, using health promotion approaches such as empowerment, mediation and advocacy. Sectors including health, education, social services and agriculture are cooperating to ensure that the spread of HIV is arrested and those infected supported.

Achievement of Organization-wide expected results

Evidence through global review of the effectiveness of health promotion collected and disseminated

Indicator	Baseline	Target	Achievement
Increase in number of projects demonstrating the effectiveness of health promotion	10	25	At least 15 projects demonstrating effectiveness of health promotion initiated or compeleted Several project results published in national or international journals

Indicator	Baseline	Target	Achievement
Dissemination of results and lessons learnt through the 6th Global Conference on Health Promotion and other channels	6 regions	6 regions	Results of 29 technical papers and 8 keynote presentations disseminated in all 6 regions

Five projects to demonstrate effectiveness of health promotion were initiated in the African Region. Under the Global Programme on Health Promotion Effectiveness, 10 projects were presented at the 18th World Conference on Health Promotion and Health Education. Best practices and approaches to promote physical activities were shared in a workshop involving 18 developing countries. The Global Programme on Health Promotion Effectiveness, set up in late 2003, aims to review and build evidence of effectiveness, translate evidence into practice and stimulate debate on the nature of evidence and effectiveness. The Programme is coordinated by the International Union for Health Promotion and Education in collaboration with WHO, with the support of 10 leading national public health/health promotion bodies in the WHO African, South-East Asia, European and Western Pacific regions and the Region of the Americas.

With regard to the dissemination of results and lessons learnt, at the 6th Global Conference on Health Promotion, involvement of health promoters from the African and Eastern Mediterranean regions as principal authors of papers and as Conference participants increased considerably.

Capability strengthened at national and regional levels for the planning and implementation of multisectoral health promotion policies and programmes across the life course and as populations age

Indicator	Baseline	Target	Achievement
Number of regions and countries that have integrated health promotion strategies into regional and national health and development plans, and effectiveness of networks at all levels to implement such strategies	2 regions	4 regions	At least 30 countries in 4 regions (African, Americas, Eastern Mediterranean and Western Pacific)
Increase in the number of health promotion courses established and personnel trained in Member States	Not established	Not established	At least 64 courses established
Number of countries that have healthy-ageing policies and programmes and mechanisms for monitoring the impact of such policies	Not established	Not established	12 countries in 5 regions (African, Americas, South-East Asia, Eastern Mediterranean and Western Pacific) made progress in improving the delivery of primary health care to older people

Regional strategies or frameworks for health promotion have been developed in the African, Eastern Mediterranean and Western Pacific regions and the Region of the Americas. Intensified actions are also under way in the South-East Asia and European regions. Member States in all regions received support in developing health promotion policies and action plans at country level, including in the area of oral health, throughout the process of developing and finalizing regional strategies and frameworks. The South-East Asia Region developed a draft health promotion framework which is expected to be finalized in 2006. The European strategy for child and adolescent health and development was adopted by the Regional Committee in 2005. The 51 designated cities in the European Region phase IV network demonstrated progress in formulating and implementing partnership-based health-development plans, with emphasis on the determinants of health and equity, and in introducing principles and programmes on healthy ageing, health impact assessment and healthy urban planning. Work is being undertaken in the African and Eastern Mediterranean regions to update regional strategies and frameworks in the light of the recommendations of the Bangkok Charter. Health promotion courses offered during the biennium included 52 courses in the African Region and the Region of the Americas and courses in 12 South-east Asian countries in oral health promotion training. Support was provided for 12 countries (Bolivia, China, Ghana, India, Jamaica, Kenya, Malaysia, Pakistan, Peru, Sri Lanka, Syrian Arab Republic, and Trinidad and Tobago) through the Ageing and Life Course and the WHO Centre for Health Development, Kobe (Japan) and through the project for an integrated response of health-care systems to rapid population ageing in developing countries in collaboration with the regional offices for Africa, the Americas, the Eastern Mediterranean, South-East Asia and the Western Pacific. Thirty-five country profiles on ageing and health were finalized in the Western Pacific Region. Healthy ageing activities

have also been implemented in the South-East Asia Region. In the Western Pacific Region, a new publication on healthy ageing[1] is intended to assist health workers in developing countries in promoting better health in older people.

Opportunities and mechanisms defined for reorienting health services towards health promotion and oral health

Indicator	Baseline	Target	Achievement
Number of countries that have integrated health promotion and oral health into their health system with specific focus on reducing known health risk factors	16	39	Policies for reorientation of oral health systems designed and are being initiated in 52 countries in all 6 regions

Health promotion capacity mapping (Stage 1) was completed in 140 Member States, allowing for better measurement of success in integrating health promotion into health systems. In Stage 2, the measurement tool will be validated and specific activities undertaken to strengthen the institutional capacity of health ministries to promote health.

Advocacy and health communications strengthened at all levels in relation to health promotion and the major risk factors, as defined in *The world health report 2002*

Indicator	Baseline	Target	Achievement
Collection and dissemination of accurate and up-to-date information related to major risk factors and healthy lifestyles for strong health promotion and media advocacy	Not established	Not established	Lifestyle-related risk factor surveys conducted in 5 countries in the Eastern Mediterranean Region and data on noncommunicable diseases collected in another 15 countries through the WHO STEPwise surveillance system

Considerable oral health data and information have been collected and disseminated, including development of the oral health information system, validation of the oral health tools and updating of the global databank. A communication plan to promote healthy lifestyles through use of role models was agreed by ten countries of the Western Pacific Region and a sizeable number of advocacy materials were produced.

Approaches to health promotion that reach young people in and out of school strengthened

Indicator	Baseline	Target	Achievement
Design of approaches to health promotion that influence youth as a whole, with links to community-based, national and international programmes	1 approach	2 approaches	1 approach (in-school health promotion) strengthened. Effort still required to develop an approach to out-of-school children and young people
Number of countries that monitor the major health-related behavioural risk factors among students, and have networks and alliances to foster concerted efforts to improve school-health programmes	33 countries monitoring risk factors Networks in 4 regions	46 countries monitoring risk factors Networks in all 6 regions	At least 53 countries have completed the Health Behaviour in School-aged Children international survey or the Global School-based Student Health Survey Networks and alliances in place in 5 regions (African, Americas, European, Eastern Mediterranean and Western Pacific regions)

Between 2002 and the end of the second quarter of 2005, over 135 000 teachers were trained in 17 countries (15 in the African Region and 2 in the Region of the Americas) to use modern, participatory learning experiences to help adults and young people acquire skills to avoid HIV infection. This joint effort by WHO, Education International and Education Development Center, Inc. will be continued for the next five years and expanded to include additional countries, funding permitting. In the Region of the Americas health risk behaviours are reportedly monitored among students entering university in almost all countries. In the Eastern Mediterranean Region 6514 health promoting schools are registered. Despite financial and human resources constraints, the Health Behaviour in School-aged Children survey and European Network of Health Promoting Schools activities continued during the biennium. In the Western Pacific Region a web-based network and registry of health promoting schools was set up. Sixteen countries in the African, Eastern Mediterranean and Western Pacific regions and the Region of the Americas completed

[1] *Healthy ageing: practical pointers on keeping well.* Manila, World Health Organization, 2005.

the Global School-based Student Health Survey in the biennium and the number of countries participating in the Health Behaviour in School-aged Children survey also increased. With regard to concerted efforts to improve school health programmes, 15 countries in the Eastern Mediterranean Region reported having a national strategy for school health in place. Efforts are being made to expand the network beyond national level.

Programmes implemented for capacity building for and financing of health promotion at local and community levels, workplace and other settings, with particular focus on improving the health of disadvantaged people

Indicator	Baseline	Target	Achievement
Healthy public policies, and promotion of the health of marginalized groups	Not established	Not established	The Bangkok Charter for Health Promotion for a Globalized World developed and adopted at the 6th Global Conference on Health Promotion
Number of health promotion foundations or other mechanisms for financing health promotion	6	6	7: one new health promotion foundation established in Mongolia during the biennium

The Bangkok Charter calls for a worldwide partnership to address the determinants of health by making the promotion of health central to the global development agenda, a responsibility of all governments, a focus of communities and civil society and a requirement for good corporate practice. In the context of the summit meetings on local development held in Peru and El Salvador, the Regional Office for the Americas provided support to the Healthy Municipalities and Communities initiative, to improve the health of disadvantaged people in Bolivia, Guatemala, Guyana, Haiti, Honduras, Nicaragua and Peru. Promotion of health for marginalized groups was also supported in the European Region through a project on prison health which attracted strong interest from countries and whose network was expanded from 18 to 28 countries in 2004. The Pro Lead pilot project has proved a success and has been expanded. The Regional Office for the Western Pacific and the WHO Centre for Health Development, Kobe (Japan) conducted a pilot test of Pro Lead for 13 health promotion managers in China, Fiji, Malaysia, Mongolia, Philippines and Tonga. Policies and programmes were set up to improve health promotion infrastructure. In Health promotion financing, twinning projects were also set up in the six countries, with support from four health promotion foundations in Australia, Switzerland and Thailand. As a result, one additional health promotion foundation was established in Mongolia in 2005.

Success factors and impediments

Success factors

- The link between health promotion and human and economic development was increasingly recognized.
- Awareness and commitment of countries to incorporating health promotion in overall health strategies increased.
- Better coordination and effective collaboration was achieved among colleagues in country offices, regional offices and headquarters.
- The focus on social determinants of health creates opportunities for collaboration between many key stakeholders at the local, country and regional levels.
- Strong support was received from many countries, nongovernmental organizations and WHO collaborating centres.

Impediments

- Relatively limited human resources allocated to this area of work by the Secretariat and Member States.
- Relatively limited expertise among health promoters to tackle the underlying determinants of ill health; the knowledge and skills needed to introduce and manage changes in different systems and settings were particularly lacking.
- Limited institutional capacity to promote health in many low- and middle-income countries, including policy and financial support for health promotion.
- Lack of policy coherence among different ministries and different levels of government.

Lessons learnt in 2004-2005 and how they will be applied in 2006-2007

- Collaboration between health promotion and other programmes needs to be strengthened in order to generate synergies and resources to implement effective health promotion. Partnerships with academic institutions, nongovernmental organizations, WHO collaborating centres on health promotion and United Nations organizations were crucial to success in many areas, such as promoting in-school health and physical activity. This will be further developed in 2006-2007. Collaboration within WHO will continue and be further strengthened.
- Reducing health inequalities is a complex task and can more readily be achieved by tackling the root causes. Worldwide partnership is required to develop a global framework for health promotion strategy, detailing the models and methods required to address the social determinants of health and implement the four commitments set out in the Bangkok Charter.
- Effective coordination not just with health ministries but also with other government sectors is crucial to success for reducing health inequalities, and holistic government approaches will be required. In 2006 and 2007, efforts will have to be made to support Member States in this regard.
- The importance of developing appropriate methods to assess the capacity of Member States to formulate, implement and evaluate policies for the promotion of population health is recognized. Efforts in this area will require further attention in 2006-2007.
- There have been examples of success in many low- and middle-income countries but those successes have not yet been properly documented and widely disseminated. Such examples should be published in national and international journals. Effort is needed to support the work of the Commission on Social Determinants of Health to build and use the evidence of the effectiveness of health promotion interventions that aim to address the root causes of good and poor health, in particular, tackling the social and economic determinants of poor health.
- There is a strong link between institutional capacity and the adoption of the evidence-based approach to health promotion. Without the expertise of individual practitioners, policy support or information systems, the evidence-based approach cannot be expanded and translation of evidence into practice will be difficult. Thus, to promote evidence-based health promotion, institutional capacity must be built, particularly in low- and middle-income countries.
- Continuing effort is required to broaden the finance base of health promotion. Ongoing effort is required to explore funding for health promotion from social insurance and private foundations.
- Thus far, the work on youth health has focused on school-aged students. An approach must be formulated to reach those out of school.
- In a globalized world and a digital era, there is a pressing need to look at how modern information and communication technologies can best be used to disseminate accurate and up-to-date information and to promote health, including examining questions of effectiveness and limited access.

Approved budget and actual expenditure

		Approved budget	Actual expenditure		
			Regular budget	Other sources	All funds
Total 2004-2005 (US$ thousand)		48 164	17 110	22 823	39 933
Percentage	countries	32	59	2	26
	regions	16	24	9	15
	global	52	17	89	59

INJURIES AND DISABILITIES

WHO objective(s)

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

Indicator(s) and achievement

- *Number of countries that have formulated policies on disabilities or prevention of violence and injuries.* Several countries have initiated the formulation of policies on disabilities or prevention of violence and injuries.
- *Number of countries implementing programmes to prevent violence and injuries.* There was a substantial increase in the number of countries implementing programmes to prevent violence and injuries. More than 100 countries appointed ministry of health focal points for injury and violence prevention to coordinate efforts.

Main achievements

- "Road safety is no accident" was the slogan of World Health Day 2004. This global advocacy event was a powerful catalyst for drawing international attention to road safety, and provided the ideal opportunity for launching the joint WHO/World Bank *World report on road traffic injury prevention.* [1]
- The Health Assembly accepted the invitation of the United Nations General Assembly for WHO to coordinate road safety efforts across the United Nations system.[2] Support to countries in implementing the recommendations of the *World report on road traffic injury prevention* was coordinated and followed up by the United Nations Road Safety Collaboration, chaired by WHO, in collaboration with the United Nations regional commissions. Collaboration focused on awareness-raising and developing detailed guidance on prevention.
- WHO launched the Global Interpersonal Violence Prevention Alliance in January 2004. Its members focus on implementing the recommendations of the *World report on violence and health.*[3] The second Milestones meeting of the Global Campaign for Violence Prevention demonstrated, through many country case-studies, the considerable progress made.
- WHO released the TEACH-VIP course on CD-ROM with a users' manual, providing 60 hours of training in violence and injury prevention.
- Important regional activities included the first meeting of francophone African health ministry officials on injury and violence prevention; meetings in the Eastern Mediterranean Region on national plans of action for prevention of road traffic injuries and on building capacities for violence prevention; a consultation in the Region of the Americas on road safety and the first regional meeting of health ministry focal points for injury and violence prevention in Europe.
- Resolution WHA58.23, on disability, including prevention, management and rehabilitation, adopted by the Health Assembly in May 2005, provided the impetus for WHO's activities in this area, and served as the basis for a six-year plan of action that includes activities in the areas of data collection, policy development, rehabilitation and assistive devices.

[1] Peden M et al. *World report on road traffic injury prevention*. Geneva, World Health Organization, 2004.

[2] Resolution WHA57.10.

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

Illustration of selected achievements

The Regional Office for Europe increased its efforts to prevent violence and injuries. In April 2004, it coordinated the celebration of *World Health Day 2004* in the Region and supported national launches of the *World report on road traffic injury prevention* in countries such as Belarus, Czech Republic, France, Denmark, Italy, Romania, Russian Federation, Sweden, Turkey and Turkmenistan. It also launched the report on prevention of road traffic injury,[1] which analyses the burden of road traffic injuries in the Region and presents the successful experiences of some European Member States. In July 2005, the Government of Slovenia hosted a Regional Consultation on Violence against Children in Europe and Central Asia (Ljubljana, 5-7 July 2005) in order to contribute to the United Nations Secretary-General's Study on Violence against Children. The Consultation was organized by the Regional Office for Europe, UNICEF, the Office of the United Nations High Commissioner for Human Rights, the Council of Europe, and the Study's nongovernmental organization advisory panel, and its final statement identified nine priority actions. The fifty-fifth session of the Regional Committee of the European Region adopted resolution EUR/RC55/R9 on prevention of injuries in the WHO European Region, providing a strategic framework for action and urging the development of national action plans; improvement of injury surveillance; strengthening of national capacity; promotion of effective injury prevention; promotion of good practice; prioritization of research in primary prevention and trauma care; and strengthening of partnerships across sectors and between stakeholders. A summary of a publication on injuries and violence in Europe was also issued.[2] The first meeting of European national focal points for violence and injury prevention was hosted by the Netherlands (Noordwijkerhout, 17-18 November 2005), providing an opportunity for national focal points from 35 European countries to share experiences and agree on goals and strategies for an informal network and on next steps.

Achievement of Organization-wide expected results

Support provided to high-priority countries for the implementation and evaluation of surveillance systems for the major determinants, causes and outcomes of unintentional injuries and violence

Indicator	Baseline	Target	Achievement
Proportion of targeted countries that use WHO guidelines to collect data on the determinants, causes and outcomes of unintentional injuries and violence	3	29	82% (26 countries)

A number of countries translated the *Injury surveillance guidelines*[3] and put in place surveillance systems using data on injuries reported by accident and emergency departments with WHO technical, and in some cases financial, support. Most of these systems are currently in the evaluation phase, following a short pilot testing period; the majority have already provided important information to the countries concerned, so that policies and programmes for violence and injury prevention can be formulated. Guidelines for conducting community surveys[4] were published and are in use in some six countries. They provide a standardized tool for data collection and a set of model questionnaires, and also focus on selection and training of fieldworkers, ethical considerations, data analysis and use of information for advocacy purposes. The WHO collaborative study on alcohol and injuries was implemented in Argentina, Belarus, Brazil, Canada, China, Czech Republic, India, Mexico, Mozambique, New Zealand, South Africa and Sweden. The International Classification of External Causes of Injuries was endorsed as a member of the WHO family of international classifications, and Version 1.2 was released in July 2004. The taxonomy is used by many countries as part of their injury surveillance systems. Translations into French and Spanish are under way.

Support provided to selected countries on research to identify effective programmes and policies to prevent violence and injuries

Indicator	Baseline	Target	Achievement
Evaluated interventions in targeted countries	2	19	26

WHO's violence prevention activities focused on supporting countries in implementing the recommendations of the *World report on violence and health* (2002), either through direct technical support or the production of guidelines. Publications for the biennium

[1] Racioppi F et al. *Preventing road traffic injury: a public health perspective for Europe*. Copenhagen, WHO Regional Office for Europe, 2004.

[2] Sethi D et al. *Injuries and violence in Europe. Why they matter and what can be done*. Copenhagen, WHO Regional Office for Europe, 2005.

[3] Holder Y et al., eds. *Injury surveillance guidelines*. Geneva, World Health Organization, 2001.

[4] Sethi D et al. *Guidelines for conducting community surveys on injury and violence*. Geneva, World Health Organization, 2004.

include: *Preventing violence: a guide to implementing the recommendations of the World report on violence and health* (2004); *Handbook for the documentation of interpersonal violence prevention programmes* (2004); and *The economic dimensions of interpersonal violence* (2004); as well as reports of the first two meetings of the Global Campaign for Violence Prevention. Following specific requests, WHO worked with a number of governments on activities such as the development of national reports and/or national plans of action to prevent violence; prevention programmes; and strengthening services for victims of violence. World Health Day 2004, on road safety, was celebrated worldwide with the slogan "Road safety is no accident", a reminder that ensuring road safety cannot be left to chance. The launch event in Paris was attended by the President of France, the Director-General and representatives of government, nongovernmental organizations and the private sector.

Guidance available for multisectoral interventions to prevent violence and unintentional injuries

Indicator	Baseline	Target	Achievement
Proportion of targeted countries that have national plans and implementation mechanisms to prevent unintentional injuries and violence	4	28	85% (24 countries)

The *World report on road traffic injury prevention*, launched in Paris on World Health Day 2004, presents a comprehensive overview of the epidemiological and prevention aspects. As a follow-up, WHO is collaborating with partners to produce a series of manuals that will provide guidance on the implementation of recommendations identified in the report. Six manuals have already been drafted: four cover helmets, seat-belts and child restraints, speed, and drinking and driving, and the remaining two focus on the establishment of a lead agency on road safety, and traffic and injury data collection. Most of these documents will be issued in 2006.

Following a consultation in 2004, guidelines for policy-makers and planners were drafted and subsequently reviewed by international experts. Technical support was also provided to several countries for the development of national plans.

Support provided for policy formulation in selected countries for pre-hospital, hospital and integrated long-term care for victims of unintentional injuries and violence

Indicator	Baseline	Target	Achievement
Proportion of targeted countries that have strengthened their health system response to unintentional injuries and violence	0	20	100% (20 countries)

In 2004, WHO and the International Society of Surgery launched the *Guidelines for essential trauma care*[1] at the 7th World Conference on Injury Prevention and Safety Promotion (Vienna, 6-9 June 2004). Their main objective was to set achievable standards for essential trauma care in all settings, and to identify the requisite human and material resources. At a consultation organized by WHO to promote implementation of the guidelines, participants elaborated implementation tools. The guidelines are currently being used in several countries, including Ghana, India, Mexico, Mozambique and Viet Nam. An Arabic translation was completed and is being used to develop a regional strategic framework for emergency medical services in the Eastern Mediterranean Region. A manual – *Prehospital trauma care systems* (2005) – focused on the establishment of such systems, particularly those requiring minimal training, equipment and supplies. The main areas covered include organization of the system, capacity development, data collection, transport and communication, and ethical and legal considerations. The manual is being used in countries such as Mozambique, Poland and Viet Nam. To ensure that sexually-abused women and children have access to adequate care, WHO followed up the initiative, launched in 2001, on strengthening the health-sector response to sexual violence. The first arm of this project aims at enhancing services for victims of sexual violence in stable, non-emergency settings. Using the *Guidelines for medico-legal care for victims of sexual violence*,[2] WHO supported governments and academic institutions in Jordan, Nicaragua and the Philippines. The guidelines were translated into Arabic and Spanish, and a French translation is in preparation.

[1] Mock C et al. *Guidelines for esssential trauma care*. Geneva, World Health Organization, 2004.

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

Support provided to high-priority countries to build capacity for prevention of injuries and violence, research and policy formulation

Indicator	Baseline	Target	Achievement
Proportion of targeted countries that have trained professionals on the prevention and management of unintentional injuries and violence	0	29	106% (31 countries)

In October 2005, WHO released the TEACH-VIP course on CD-ROM with a users' manual, providing training in violence and injury prevention. It had been elaborated by more than 60 violence and injury prevention experts across 19 countries and pilot tested in more than 20 settings worldwide. Created to meet the call by governments and professional groups for specialist knowledge in the area of injuries and violence, TEACH-VIP covers a wide range of topics, including data collection, violence and injury prevention, policy development, and evaluation of intervention measures, and is in considerable demand.

Global, regional and national initiatives taken to strengthen collaboration between health and other sectors involving organizations in the United Nations system, Member States and nongovernmental organizations

Indicator	Baseline	Target	Achievement
Number of global, regional and national multisectoral initiatives in place to prevent violence and injuries	1	8	8

In January 2004 the Violence Prevention Alliance was launched. Its members – governments, nongovernmental organizations and foundations – share a public health approach to preventing violence, and focus on implementing the recommendations of the *World report on violence and health*. The second Milestones meeting of the Global Campaign for Violence Prevention, hosted by WHO and the California Wellness Foundation, demonstrated through many country case-studies the considerable progress made by governments, nongovernmental organizations and academia in the areas of data collection, violence prevention, and services for victims. Support to countries in implementing the recommendations of the *World report on violence and health* is being coordinated and followed up by the United Nations Road Safety Collaboration (a network of 11 United Nations agencies and more than 30 global, regional and national road safety organizations), under WHO's chairmanship. Three meetings of the Collaboration focused on developing detailed guidance for countries on prevention and awareness raising. ILO, UNESCO and WHO, the three key partners in the development of the joint position paper on a strategy for community-based rehabilitation,[1] joined with a group of nongovernmental organizations and other agencies to create a community-based rehabilitation network. Other groups with which WHO has partnerships include the Associazione Italiana Amici di Raoul Follereau, Christoffel-Blindenmission, Disabled Peoples' International, Handicap International, International Disability and Development Consortium and Sight Savers International, among others. Together, these groups fund more than 400 community-based rehabilitation projects throughout the world.

Ability of countries to integrate rehabilitation services into primary health care, for early detection and management of disabilities

Indicator	Baseline	Target	Achievement
Proportion of targeted countries implementing strategy for integrating rehabilitation services into primary health care	7	15	80% (12 countries)

WHO's work in the area of disability and rehabilitation is guided by resolution WHA58.23 on disability, including prevention, management and rehabilitation, adopted by the Health Assembly in May 2005, which calls for strengthened implementation of the United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities; support for community-based rehabilitation; the inclusion of a disability component in national health policies and programmes; and promotion of the rights and dignity of people with disabilities. As a follow-up, WHO drew up the disability and rehabilitation action plan 2006-2011, which focuses on producing a world report on disability and rehabilitation; raising awareness; facilitating data collection and analysis; supporting, promoting and strengthening health and rehabilitation services; promoting community-based

[1] *Community-based rehabilitation: a strategy for rehabilitation, equalization of opportunities, poverty reduction and social inclusion of people with disabilities*. Geneva, World Health Organization, 2004.

rehabilitation; promoting development, production, distribution and servicing of assistive technology; supporting the development, implementation, measuring and monitoring of policies; building capacity and fostering multisectoral networks and partnerships. Implementation of the plan started, following consultations, with the development of normative documents on strengthening medical care and rehabilitation services, on the provision and maintenance of wheelchairs, on community-based rehabilitation and on self-management activities for people with disabilities.

Success factors and impediments

Success factors

- Establishment of a strong team in headquarters and regional offices, with complementary skills, strong competence and high motivation.
- Good collaboration between headquarters, regional and country offices.
- Clear vision for building up the programme.
- Delivery of a steady flow of highly visible products and events, which gave the programme and its issues a high profile.

Impediments

- High level of financial uncertainty, which complicated long-term planning and limited allocation of adequate resources.
- Inadequate level of staffing and technical knowledge of the field in many country offices.
- Low level of priority given to the area of work in certain countries.

Lessons learnt in 2004-2005 and how they will be applied in 2006-2007

- It is important to provide sustained support to a limited number of countries. This will require the presence of full-time staff in certain country offices.
- Resource constraints have affected the area of work and further efforts will need to be made to ensure continuity of resources over several years.
- Consistent and targeted messages are a key to success. A major focus of this area of work will therefore continue to be on the implementation of the recommendations of the world reports on violence and health and on road traffic injury prevention.
- It is important to continue efforts to improve joint planning between all levels of the Organization. This will be pursued through annual planning meetings and regular telecommunications.
- Highly visible products are required together with sustained effort for their implementation. To achieve this, capacity will need to be strengthened in some areas.

Approved budget and actual expenditure

		Approved budget	Actual expenditure		
			Regular budget	Other sources	All funds
Total 2004-2005 (US$ thousand)		17 633	4 354	8 874	13 227
Percentage	countries	30	26	13	17
	regions	18	24	18	20
	global	52	50	69	63

MENTAL HEALTH AND SUBSTANCE ABUSE

WHO objective(s)

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

Indicator(s) and achievement

- *Proportion of targeted countries that have implemented reforms in the area of mental health.* Eighteen countries have embarked on implementation of policy reform with direct support from WHO.
- *Number of countries that have increased their budget for mental health.* Owing to the nature of the procedure for deriving mental health budget figures from national health budgets, it is not possible to establish the number of countries that have increased their budgets for mental health.

Main achievements

- In keeping with the commitment made in the global action programme for mental health endorsed by the Health Assembly in 2002, WHO has been able to achieve a higher level of awareness and political support for mental health and substance abuse. WHO, in conjunction with the European Union and Council of Europe, organized the European Ministerial Conference on Mental Health (Helsinki, January 2005), and, with PAHO, a regional conference on mental health services reform (Brasília, 7-9 November 2005).
- An initiative on mental health policy, legislation and human rights was developed. This is supported by a network of experts, comprehensive normative material and sustained country support.
- The WHO European Ministerial Conference on Mental Health endorsed an action plan and declaration, generating political commitment to detailed policy decisions in countries.
- WHO initiated public health action in respect of several severe disorders, including epilepsy, and to prevent suicide and treat substance-abuse at primary care level. These problems constitute a substantial burden, and there is a lack of treatment in most low- and middle-income countries.
- WHO provided fresh impetus and clear direction for mental health assistance during and after emergencies and disasters, including the tsunamis and earthquakes in 2005, and conflicts and wars. This work, closely coordinated between headquarters, regional and country offices, and other United Nations agencies, has provided a more effective and evidence-based response to affected communities.
- WHO made significant progress in human resources training for mental health and research. This is particularly important for low- and middle-income countries where capacity in both areas is inadequate.

Illustration of selected achievements

The mental health atlas: 2005[1] – a joint product of headquarters, regional and country offices – has fulfilled a long-felt need for basic information on mental health. It provides essential information on mental health resources and services, including epidemiological information for all low- and middle-income countries. Specific versions have been developed for child and adolescent mental health, neurology, epilepsy and psychiatric education and training. The atlases are used widely by governments and nongovernmental organizations, and researchers within countries.

Achievement of Organization-wide expected results

Appropriate strategies developed and support provided to countries in reducing stigmatization and violations of human rights associated with mental and neurological disorders and substance abuse

Indicator	Baseline	Target	Achievement
Proportion of targeted countries that, in consultation with WHO, have initiated	0	20	110% (22 countries)

[1] *Mental health atlas: 2005*. Geneva, World Health Organization, 2005. Database accessible at http://www.who.int/mental_health/evidence/atlas/.

Indicator	Baseline	Target	Achievement
strategies to draw up mental health legislation; to promote human rights; and to reduce stigmatization through social communication programmes			

Normative and country work was pursued successfully in the area of mental health legislation and human rights through close collaboration between headquarters, regional and country offices. International capacity in this area has been enhanced with the training of more than 50 experts using WHO's framework on mental health, human rights and legislation. A resource book on rights and legislation[1] has been translated into five languages and attracted substantial media coverage. Countries in the process of drafting or revising their mental health legislation include China, Ghana, India, Indonesia, Iraq, Maldives, Mauritius, Papua New Guinea, Rwanda, Samoa, Sri Lanka and Thailand. Activities to promote the human rights of the mentally ill were carried out in countries including Burundi, Cameroon, Cape Verde, Congo, Ethiopia, Indonesia, Kenya, Malawi, Mozambique, Namibia, Niger, Republic of Moldova, Senegal, Serbia and Montenegro, Sri Lanka, Swaziland, Thailand, The former Yugoslav Republic of Macedonia and Zambia. Social communication activities to reduce stigmatization and discrimination against the mentally ill were also carried out in most countries. Support has also been provided to some countries in establishing and/or strengthening advocacy groups on human rights.

Information and support given to countries in formulating and implementing policies and plans on mental health and substance use

Indicator	Baseline	Target	Achievement
Number and proportion of targeted countries for which information or data have been translated and adapted according to country needs	0	12	100 % (12 countries)
Number and proportion of targeted countries that received technical assistance from WHO in developing and implementing policies and plans	0	24	125 % (30 countries)

WHO's mental health policy and service guidance package was finalized, printed and disseminated widely. Many modules have been translated into WHO's official languages and into several other languages. WHO suicide prevention resource material has also been translated into nine languages. Technical assistance in mental health policy and plans has been provided to many countries and territories including Afghanistan, Bahrain, Egypt, Ethiopia, Gambia, Guinea-Bissau, Islamic Republic of Iran, Kuwait, Latvia, Lesotho, Morocco, Mozambique, Namibia, Oman, Samoa, Saudi Arabia, Sri Lanka, Tunisia, United Arab Emirates, West Bank and Gaza Strip, and Zimbabwe. An important step towards improving policies for the treatment of opioid-dependent people was the inclusion of methadone and buprenorphine in the WHO Model List of Essential Medicines. Assistance on substance-abuse policy and plans was provided to some countries, including Indonesia, Islamic Republic of Iran, Lithuania and Ukraine. WHO's expert report on neuroscience of substance abuse and dependence[2] was launched and disseminated in all regions and translated into 10 languages. Thirty-three Member States in the European Region received assistance on plans for management of substance abuse problems in prisons.

Global and regional alcohol research and policy initiatives established and implemented

Indicator	Baseline	Target	Achievement
Proportion of targeted countries that adapt alcohol policy guidelines according to their needs	0	4	100% (4 countries)
Proportion of targeted countries that have undertaken research on alcohol-related topics in line with those promoted by WHO	0	9	166% (15 countries)

[1] *WHO resource book on mental health, human rights and legislation.* Geneva, World Health Organization, 2005.

[2] *Neuroscience of psychoactive substance use and dependence.* Geneva, World Health Organization, 2004.

Technical advice and assistance on alcohol policy were given to a number of countries, including Bhutan, India, Indonesia, Malawi, Mozambique, Myanmar, Namibia, Nepal, Sri Lanka and Thailand. Training courses on early identification and management of alcohol problems in primary care were supported in some countries, including Brazil, Fiji, Mongolia and South Africa. Research on alcohol-related topics has been supported in a variety of ways, including support for implementation of the International Study on Gender, Alcohol and Culture in Argentina, Costa Rica, India, Kazakhstan, Nigeria and Sri Lanka; national epidemiological study on alcohol in Mongolia; estimation of social and economic cost of alcohol-related problems in China; and other ad hoc projects in Bhutan, India, Indonesia, Myanmar, Nepal, Sri Lanka and Thailand. These activities provided a strong base for planned expansion of WHO activities in the area of the harmful effects of alcohol in the 2006-2007 biennium.

Instruments, guidelines and training packages available in countries for the management of mental and neurological disorders and substance abuse; adequate support provided to countries for their implementation, with the needs of vulnerable groups (e.g. poor people, injecting drug users and those living with HIV/AIDS) as well as gender-specific needs taken into account

Indicator	Baseline	Target	Achievement
Proportion of targeted countries that received WHO support to incorporate WHO's tools and materials for assessment and management of clinical situations and needs, and for staff development	6	24	100% (24 countries)
Proportion of countries in which WHO either promoted or helped to coordinate support to the mental health needs of the most vulnerable population groups	6	18	100% (18 countries)

The Global Campaign Against Epilepsy, launched by WHO in collaboration with two international nongovernmental organizations, led to a number of activities in regions and countries. Regional reports were prepared for the African, South-East Asia and Western Pacific regions. A demonstration project was completed in China and new demonstration and pilot projects initiated in China, Georgia, India, Maldives, Myanmar and Viet Nam. Draft guidelines on the management of epilepsy among children and adolescents were also formulated. Direct technical assistance in developing national suicide prevention programmes was provided to countries including Benin, Brazil, China, Japan, Paraguay, Singapore, Uruguay and Viet Nam. Resource material on mental health and HIV/AIDS therapy was also developed. Training and technical assistance in the management of childhood and adolescent mental disorders, especially among vulnerable populations, were provided to professionals from 26 countries in the African Region and eight countries in the South-East Asia Region. A global campaign to reduce the burden of headache was launched. National training courses on management of mental disorders were held in all countries of the Eastern Mediterranean Region, and on drug substitution therapy in China, Indonesia, Islamic Republic of Iran, Lithuania, Poland and Thailand. Essential medicines were provided to countries including Afghanistan, Congo, Djibouti, Iraq and Somalia. Comprehensive assistance in the area of mental health was also provided to countries and territories affected by emergencies and disasters, including those affected by the December 2004 tsunamis (Indonesia, Maldives and Sri Lanka) and by conflicts and war (Afghanistan, Iraq, Sudan, and West Bank and Gaza Strip). This assistance was targeted on the most vulnerable groups in those countries.

More valid and reliable scientific, epidemiological and resource data available for planning and development of cost-effective interventions in the mental health and substance abuse area; measures of the burden attributable to such disorders accessible to countries

Indicator	Baseline	Target	Achievement
Number (and regional representation) of countries for which data are included in epidemiological databases	0	Revised database for low- and middle-income countries	192 countries included and database revised to include all low- and middle-income countries
Number and proportion of targeted countries receiving WHO's technical assistance in drawing up protocols for cost-effective interventions	0	6	133% (8 countries)

In addition to the revised and updated *Mental health atlas: 2005*, Atlas volumes on neurology, epilepsy and child and adolescent mental health were published.[1] The WHO assessment instrument for mental health systems was developed and implemented in 12 countries, Albania, Barbados, Ecuador, India, Latvia, Kenya, Pakistan, Republic of Moldova, Senegal, Sri Lanka, Tunisia and Viet Nam, and initiated in many more countries. The global suicide data were updated and epidemiological data collected from a number of countries including Brazil, China, Estonia, India, Islamic Republic of Iran, South Africa, Sri Lanka and Viet Nam. Information on the cost-effectiveness of mental health interventions was compiled and made available to all regions and to countries including Estonia, Nigeria and Sri Lanka. Technical assistance in this area was provided to six countries in the South-East Asia Region and eight countries in the European Region.

Appropriate support provided for building capability in developing countries for policy development and research on mental and neurological disorders and substance abuse

Indicator	Baseline	Target	Achievement
Number of fellowship programmes established to provide training to researchers from developing countries in public health aspects of mental health and substance dependence	2 researchers	12 researchers	17 researchers

Several activities in the area of research capacity building within countries were initiated or supported. The WHO Mental Health Fellowship Programme was expanded to five sites and trained seven Fellows from low- and middle-income countries. One training programme was held in Ethiopia to train 12 researchers from the African Region and three meetings were held in the South-East Asia Region to build capacity and prioritize research in mental health. In the area of substance abuse, WHO provided travel fellowships to 10 researchers. Research capacity-building activities were also conducted in Iraq. A comprehensive assessment of research infrastructure was carried out in six countries, Brazil, Hungary, Mexico, Pakistan, Poland and Turkey, and mental health research was mapped in three regions in collaboration with the Global Forum for Health Research.

Success factors and impediments

Success factors

- WHO's continuing development of normative material in the areas of mental health and substance abuse was a major success factor for effective implementation of activities. Given the early stage of development of these areas from a public health perspective, these materials are needed to guide all country programmes.
- Close working relationship between headquarters, regional offices and country offices made effective implementation of the programme possible. The appointment of subregional professional staff was particularly useful for maintaining an effective presence within countries.
- Given the small size of WHO's mental health and substance abuse team, partnerships with other organizations were essential in advancing WHO's vision in these areas.

Impediments

- Resource constraints were the most serious impediment in these areas. In addition, the decentralization of 70% of resources further limited the scope for undertaking the global normative work requested by some Member States.
- Lack of capacity for mental health within country offices seriously restricted implementation of activities in the areas of mental health and substance abuse within countries.
- Low priority given to mental health and substance abuse within health ministries continued to impede expansion of activities in these areas.

Lessons learnt in 2004-2005 and how they will be applied in 2006-2007

- Further strengthening of essential normative activities is required and will be undertaken in 2006-2007 to facilitate successful implementation of country programmes.

[1] *Atlas: country resources for neurological disorders.* Geneva, World Health Organization, 2004; *Atlas: epilepsy care in the world.* Geneva, World Health Organization, 2005; *Atlas: child and adolescent mental health resources: global concerns: implications for the future.* Geneva, World Health Organization, 2005.

- The capacity of WHO country offices to provide local technical expertise and supervision to country programmes must be increased in 2006-2007.
- More innovative resource mobilization will be sought in an attempt to reduce the resource deficit of this area of work. The potential resource generation at regional and country levels has largely remained untapped; this situation needs to be rectified.

Approved budget and actual expenditure

		Approved budget	Actual expenditure		
			Regular budget	Other sources	All funds
Total 2004-2005 (US$ thousand)		23 856	11 893	8 782	20 675
Percentage	countries	38	29	9	21
	regions	32	33	48	39
	global	30	38	43	40

CHILD AND ADOLESCENT HEALTH

WHO objective(s)

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

Indicator(s) and achievement

Number of countries receiving technical support from WHO to build capacity to implement interventions and to apply measurement tools. A total of 121 countries received technical support from WHO through country visits or technical consultations.

Main achievements

- Significant progress was made in the development of regional and national strategies. The Western Pacific Region's joint WHO/UNICEF Regional Child Survival Strategy was endorsed by the Regional Committee; the European strategy for child and adolescent health and development was adopted by the Regional Committee; the Eastern Mediterranean Region launched the Child Health Policy Initiative, developed the regional Strategic directions for promoting adolescent health and development, and supported the development of national strategies for adolescent health. The African Region started to develop a child survival strategy and Member States of the Region of the Americas and the South-East Asia Region developed national neonatal health strategies.
- Linkages for the mother-newborn-child continuum of care were strengthened. Joint programming in maternal health and child health was initiated in the African, South-East Asia and European regions to promote newborn health. In the African Region, the regional Reproductive Health Task Force was expanded and renamed the Regional Task Force for Maternal, Newborn, and Child Health; in the Region of the Americas, an interagency regional neonatal strategy was initiated to promote the mother-newborn-child continuum of care.
- Implementation of Integrated Management of Childhood Illness was expanded in 27 Member States of the African Region, seven in the Region of the Americas, five in the South-East Asia Region, 14 in the European Region, 11 in the Eastern Mediterranean Region, and 13 in the Western Pacific Region. The multicountry evaluation of the effectiveness, cost and impact of this strategy showed a 13% mortality reduction in the United Republic of Tanzania (over two years) with no additional cost, and a three-fold increase in use of public facilities for severe child illness in Bangladesh.
- Advocacy efforts produced good results. The series on newborn health in *The Lancet* (co-authored by WHO) and *The world health report 2005*[1] led to increased focus on newborn health in the African Region, the Region of the Americas and the South-East Asia Region; the profile of maternal, newborn and child health was raised in the South-East Asia Region (where the report was launched); in the Eastern Mediterranean Region, national public health days attracted high-level participation, and a child and adolescent health web site was launched.
- Adolescent-friendly health services were given greater priority. In the South-East Asia Region, they were accorded priority in eight Member States, and adolescent health and development was included in intersectoral programmes in two Member States; in the African Region staff from 32 Member States were oriented to the concept of such services. In addition to the 29 Member States in the Region of the Americas with national adolescent health programmes, six others formulated plans for youth development and violence prevention. In the European Region, adolescent-friendly health services were mapped in 17 Member States.
- Partnerships were strengthened. The regional offices of WHO and UNICEF signed a joint communiqué on child survival interventions in the African Region, and the African Union approved a decision on scaling up child survival interventions; strong partnerships in the European Region led to successful fund-raising; strategic partnerships in the South-East Asia Region resulted in stronger national action to reduce HIV among young people; in the Western Pacific Region, a regional child survival strategy was developed in collaboration with UNICEF's East Asia and the Pacific Regional Office. The Region of the Americas developed partnerships with professional associations for neonatal resuscitation; with United Nations agencies, nongovernmental organizations, the private sector and civil society further partnerships were developed for child and adolescent health. WHO and partners launched the Global Partnership for Maternal, Newborn and Child Health, and national partnership activities were initiated in a number of countries. The Regional Office for South-East Asia and UNICEF agreed to collaborate on regional guidelines on paediatric HIV and antiretroviral therapy.

[1] *The world health report 2005: Make every mother and child count.* Geneva, World Health Organization, 2005.

Illustration of selected achievements

As a result of intensified advocacy to improve child and newborn survival through the publication of the child survival and neonatal survival series in *The Lancet, The World Health Report 2005* and World Health Day 2005, three countries (Ethiopia, Madagascar and Zambia) finalized national child health strategies or policies and four others (Kenya, Mozambique, Nigeria, and the United Republic of Tanzania) initiated the process. All seven countries were supported by the Regional Office for Africa. These strategies or policies emphasized integrated implementation of selected cost-effective interventions in order to reduce the high child mortality rates in the Region. To mainstream support to countries, the Regional Office for Africa and UNICEF signed a communiqué identifying interventions for joint support. With input from the Regional Office for Africa and UNICEF, the African Union passed the Tripoli Declaration emphasizing the need to scale up selected cost-effective interventions in order to achieve Millennium Development Goal 4. As Goals 4 and 5 are interlinked and neither one can be fully achieved without the other, the Regional Director expanded the regional reproductive health task force into a regional task force for maternal, newborn and child health to facilitate support to countries within the framework of the continuum of care from pregnancy through childbirth and the newborn period to childhood.

Achievement of Organization-wide expected results

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

Indicator	Baseline	Target	Achievement
Number of countries that have initiated implementation of child and adolescent health-related recommendations in accordance with WHO support to the reporting process of the Convention on the Rights of the Child	3	8	14

Headquarters activities in the area of child and adolescent rights focused primarily on working with partners to explore the practical application of the Convention on the Rights of the Child and other legal instruments to plans and programmes targeting child and adolescent health. Direct support to the United Nations Committee on the Rights of the Child was provided for a number of countries, and subregional and national child rights workshops were organized in collaboration with regional offices, UNICEF and the Office of the United Nations High Commissioner for Human Rights. However, some regional offices reported a lack of capacity to follow up this expected result, and additional capacity is being built to enable regions to give better support to countries in applying the Convention and the recommendations of the Committee in future.

Improved policies, strategies, norms and standards for protecting adolescents from disease and health risk behaviours and conditions established through research, technical and policy support

Indicator	Baseline	Target	Achievement
Number of countries with policy recommendations and guidelines influenced by WHO-supported research projects on protecting adolescents from the major diseases and health risk behaviours and conditions	20	30	32
Number of countries with national adolescent health policies and programmes	20	30	49

This work focused on the introduction and implementation of adolescent-friendly health services, the approach of the Alliance of Parents, Adolescents and the Community, and the framework for mapping and evaluating programmes targeting adolescents. Some regional offices did not provide information for this expected result owing to staff shortages; others did not provide quantitative data.

Guidelines, approaches and tools in place for more effective and expanded implementation of integrated management of childhood illness, and monitoring of progress validated and promoted

Indicator	Baseline	Target	Achievement
Number of countries implementing integrated management of childhood illness activities that have expanded geographical coverage to more than 50% of target districts	20	25	25
Number of research projects supported by WHO aiming to influence the formulation of strategic norms, standards and guidelines for improving child survival	40	50	80
Number of countries with national child health policies and action plans based on WHO standards and guidelines	8	16	At least 44

Implementation of Integrated Management of Childhood Illness expanded in target countries in all regions, and universal coverage became the principal challenge. Pre-service training for medical and paramedical staff and the priority given to it were increased, as were community interventions for child health (both the provision of services at community level, and the promotion of family practices). Research projects were developed to address gaps in technical knowledge and in how best to deliver interventions, and results were quickly translated into action.

Support provided for research and for the development of guidelines, approaches and tools for better implementation of interventions to reduce newborn mortality and improve newborn health

Indicator	Baseline	Target	Achievement
Number of research projects supported by WHO aiming to influence the formulation of strategic norms, standards and guidelines for improving newborn health	3	6	10
Number of countries having adopted the guidelines	0	8	18 more have done so

It became clear that newborn health and child health could not be separated (as reflected in the Organization-wide expected results for 2006-2007), and that interventions for newborn and maternal health were interlinked, thus requiring the forging of strong links between child health and maternal health programmes. Regional advisers were given guidance on a framework for newborn health, in order to build capacity for supporting countries in this area.

Consensus reached on definition of global goals in raising healthy children and confident, competent adolescents, and progress towards their attainment

Indicator	Baseline	Target	Achievement
Number of countries with child survival partnership mechanism established to support coordinated action in implementation of child health interventions	0	15	8
Number of countries applying WHO's strategic approach to HIV and young people	3	10	20 (10 of which are in the Region of the Americas)

In addition to the child survival partnership mechanisms and the strategic approach to HIV and young people, some 40 countries implemented the global strategy for infant and young child feeding, which includes policy, strategy, and capacity development on infant feeding in the context of HIV. The focus from child survival to maternal, newborn and child survival was reflected in some regions. A good example of partnership was the development by the Regional Office for the Western Pacific, in collaboration with UNICEF's East Asia and the Pacific Regional Office, of an outcome-oriented regional child survival strategy which aims to reduce inequities in child survival and support achievement of national targets for Millennium Development Goal 4 by improving access to, and utilization of, an essential package of evidence-based child survival interventions.

Success factors and impediments

Success factors

- Linkages between WHO programmes and areas of work, particularly Child and adolescent health with Making pregnancy safer, HIV/AIDS and Nutrition.
- Strengthened partnerships and interagency collaboration with United Nations organizations (UNICEF, UNFPA and UNAIDS), bilateral agencies, professional associations and nongovernmental organizations at regional and country levels for expanding interventions.
- Advocacy and high-level political support, including support of the regional directors and of regional governing bodies.
- Strong collaboration between all levels of the Organization and joint planning across the area of work.
- Strong regional teams with focal points for both child health and adolescent health, and WHO staff in some countries.

Impediments

- The general lack of funds, and the availability of unspecified funds for discretionary use and country support.
- The allocation of regular budget funds at regional and country level that does not reflect the high priority accorded by WHO to child and adolescent health.
- Inadequate staff numbers and capacity at all levels of the Organization, particularly for adolescent health. In some regions, positions have remained vacant for some time.
- Lack of technical evidence for the effectiveness of adolescent-related interventions and their delivery.

Lessons learnt in 2004-2005 and how they will be applied in 2006-2007

- Partnerships have been effective in accelerating implementation of child and adolescent health strategies at country level, and collaboration must be continued and strengthened to ensure commonality (or complementarity) of efforts, common coordination structures, joint planning, and better mobilization of resources.
- Expected results are more likely to be achieved when work is focused on a limited number of feasible activities. The goal driving efforts should be full coverage of existing and proven interventions.
- WHO must concentrate on building capacity at all levels, and on strengthening regional and country teams.
- Continuous advocacy aimed at partners and Member States is critical for scaling up child and adolescent health interventions at all levels. There will be an increased focus on advocacy in 2006-2007.
- The health and survival of the child is dependent on the health and survival of the mother. In 2006-2007, continuum of care will be promoted at all levels from pregnancy through childbirth to childhood; and from the home to primary health care and through to referral facilities. More collaboration is needed with the Making pregnancy safer and Nutrition areas of work.

Approved budget and actual expenditure

		Approved budget	Actual expenditure		
			Regular budget	Other sources	All funds
Total 2004-2005 (US$ thousand)		67 349	15 355	38 676	54 032
Percentage	countries	31	49	10	21
	regions	33	20	40	34
	global	36	31	50	45

RESEARCH AND PROGRAMME DEVELOPMENT IN REPRODUCTIVE HEALTH

WHO objective(s)

To contribute, through research and support for elaboration of policies and programmes, to a reduction in morbidity and mortality related to sexual and reproductive health and to implementation of accessible, equitable, gender-sensitive and high-quality reproductive health services in countries.

Indicator(s) and achievement

Number of completed studies of causes, determinants, prevention and management of sexual and reproductive morbidity and mortality. Nineteen studies were completed out of a target of 40.

Number of countries provided with technical support to assess the scope and quality of their current reproductive health care services and identify possible approaches to improving services, including integration of HIV prevention and care activities. Intensive support was provided in more than 25 countries, well over the target of 20.

Main achievements

- In collaboration with partners and with UNFPA in particular, technical and policy support was provided for the development of national programmes for sexual and reproductive health in over 60 countries in all WHO regions. The WHO/UNFPA Strategic Partnership Programme, initiated in 2004, was critical to this effort. The Programme supports a coordinated process of introduction, adaptation and implementation of guidelines in countries, with support from technical advisers from WHO, UNFPA and other cooperating agencies, under the leadership of the respective health ministries.
- In 2004, the Health Assembly adopted resolution WHA57.12 endorsing the strategy to accelerate progress in reproductive health – a step that was instrumental in national programme development. The strategy sets out the major discrepancies between global goals and global realities, and describes the principal barriers to progress, noting in particular the inequities related to gender and poverty and the exposure of adolescents to risk. With the aim of accelerating progress towards the attainment of international development goals and targets related to reproductive health, it lays out a strategy for action, which is guided by principles based on international human rights. WHO worked with Member States to implement the strategy at the national level.
- A total of 19 global and national research projects, supported by the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction, were completed during the biennium.
- The critical interface between sexual and reproductive health and HIV/AIDS became an important focus of the Organization in this area of work.
- In the South-East Asia Region, adaptation and field testing of tools for assessing malaria in pregnancy were successfully carried out in Bangladesh, India, Indonesia and Myanmar; a national family planning strategy was developed in Timor-Leste; family planning guidelines were adapted in Bangladesh, Maldives and Timor-Leste; and activities to prevent unsafe abortion were implemented in Bangladesh, Nepal and Thailand.
- In the Western Pacific Region, a regional framework for accelerating action on sexual and reproductive health of adolescents and young people was developed, acknowledging and addressing in particular the sexual and reproductive health needs of young people. Additionally, programme reviews were systematically carried out in order to increase awareness of and improve adolescent sexual and reproductive health.
- In the European Region, as a result of the adoption of the WHO strategy to accelerate progress in reproductive health, national strategies were developed and approved in Kyrgyzstan, the Republic of Moldova and Tajikistan, and the process of development or approval is under way in Ireland, Kazakhstan, Kosovo (Serbia and Montenegro) and Uzbekistan.
- In the Region of the Americas, individual clinical-and community-level prototype models for involving men in sexual and reproductive health programmes were elaborated and designed in Costa Rica, El Salvador, Honduras, Nicaragua and Panama.
- The results of a study conducted in the African and Eastern Mediterranean regions, on obstetric sequelae of female genital mutilation, showed that women who have undergone the procedure are significantly more likely to have complicated deliveries, and that the risk increases with more extensive mutilation.

- The conclusions of a consultation in June 2005 to assess the evidence on the link between the use of hormonal contraceptives and bone health were published in the *Weekly Epidemiological Record* and widely disseminated.[1] Experts agreed that the benefits of these contraceptives (including progestogen-only methods) generally outweigh the risks of bone loss.
- The first part of the WHO global survey on maternal and perinatal health was completed in the African Region and the Region of the Americas; it included some 250 hospitals and 180 000 deliveries.

Illustration of selected achievements

Strengthening of family planning programmes in the African Region took a new turn with the development and adoption of the 10-year framework for repositioning family planning, by all health ministers at the Regional Committee meeting in September 2004. The Implementing Best Practices Initiative was launched in the African Region in June 2004 with a view to sharing experiences and implementing best practices in sexual and reproductive health. Twelve countries participated and five are now implementing activities.

Achievement of Organization-wide expected results

New knowledge available on high-priority issues in sexual and reproductive health throughout the life-cycle, including cross-cutting themes such as the role of men, integration of HIV/AIDS prevention and care in reproductive health services, adolescent sexual and reproductive health, and the impact of health care reforms on reproductive health care

Indicator	Baseline	Target	Achievement
Number of completed studies of priority issues in reproductive health	Existing evidence base	40 studies	19 completed
Number of new and updated systematic reviews on best practices, policies and standards of care	Existing portfolio of systematic reviews	15 new or updated systematic reviews	19 reviews

Global and national research was supported by the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction. Projects were completed on topics including the association between the use of hormonal contraceptives and bone health, the safety and efficacy of two intrauterine devices, calcium supplementation for the prevention of pre-eclampsia, the incidence and risk factors for pelvic inflammatory disease, and manual evacuation abortion services provided by trained midwives. In addition to this research of global relevance, well over 100 research studies were conducted in the centres receiving research capacity-strengthening support from the Special Programme. In addition, the process for "continuous identification of research evidence" was used to identify and critically appraise new evidence relevant to WHO family planning guidance on several medical conditions; six systematic reviews were updated as a result. New evidence relating to seven contraceptive practice recommendations was also identified, leading to the updating of five systematic reviews. A systematic review of maternal mortality and morbidity was also completed, covering the causes of maternal mortality, the prevalence of uterine rupture and other topics.

Cost-effective interventions that promote high-quality reproductive health care that is client-centred and gender-sensitive designed, applied and validated through operational research

Indicator	Baseline	Target	Achievement
Number of countries completing operational research studies to evaluate approaches to provision of high-quality reproductive health care	Existing national evidence bases	15 countries	11 countries

Operational research was carried out in a number of countries. In Kenya, a study evaluated the impact of the introduction of the guide on sexually transmitted and other reproductive tract infections[2] on the integration of the response to such infections into reproductive health and primary health-care settings. Guided by WHO's strategic approach to improving quality of care in reproductive health services, an operational research study to develop reproductive health services for female factory workers began in Romania. A number of operational research projects were also implemented in collaboration with the Population

[1] WHO statement on hormonal contraception and bone health. *Weekly Epidemiological Record* 2005; **80**: 297-304.

[2] *Sexually transmitted and other reproductive tract infections: a guide to essential practice.* Geneva, World Health Organization, 2005.

Council's "Frontiers in Reproductive Health Program", which used operational research techniques to improve reproductive health service delivery.

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

Indicator	Baseline	Target	Achievement
Availability of new or updated materials to support national efforts to improve reproductive health	Existing portfolio of guidance materials	8 additional guides disseminated	5
Number of countries receiving technical support for the adaptation of evidence-based standards for essential care practice in reproductive health	20 countries	20 additional countries	More than 25 countries received intensive technical support

WHO continued to support the development of evidence-based norms, standards and clinical guidelines: a *Decision-making tool for family planning clients and providers* was published,[1] the *Medical eligibility criteria for contraceptive use*, 3rd ed. (2004) and *Selected practice recommendations for contraceptive use*, 2nd ed. (2004) were translated into six and seven languages respectively, and introduced in 60 countries through six regional workshops; the guide on sexually transmitted and other reproductive tract infections was translated into Chinese and French; translations of the *Guidelines for the management of sexually transmitted infections* (2003) into French, Spanish and Portuguese were completed; and a practical guide was finalized for service providers responding to frequently asked questions on medical abortion.

Adequate policy and technical support provided to selected countries for the implementation of comprehensive plans for strengthening access to, and availability of, high-quality reproductive health care, human resources, and monitoring and evaluation

Indicator	Baseline	Target	Achievement
Number of countries receiving support to strengthen access to, and availability of, high-quality reproductive health care	20 countries	20 additional countries	More than 20

Technical and/or policy support was provided to a large number of countries, primarily through the regional and country offices. Many countries used the strategy to accelerate progress in reproductive health, in order to integrate sexual and reproductive health further into their national development policies and to identify problems, set priorities and monitor progress towards sexual and reproductive health goals.

Technical support provided to selected countries to examine their national laws, regulations and policies for conformity with articles of existing legal instruments, conventions, and international consensus documents related to sexual and reproductive health and rights

Indicator	Baseline	Target	Achievement
Number of countries receiving support to examine their existing national laws, regulations and policies relating to reproductive health and rights	None	3 countries	3

Countries received support to examine their existing national laws, regulations and policies on reproductive health and rights through a new product – "Using human rights for maternal and neonatal health: a tool for strengthening laws, policies and standards of care". This tool was implemented in Brazil, Indonesia and Mozambique.

Success factors and impediments

Success factors

- WHO's strategy to accelerate progress in reproductive health provided an important impetus and a strong mandate for intensified action by country and regional offices and headquarters.

[1] Accessible online at http://www.who.int/reproductive-health/family_planning/counselling.html.

- Strong coordination with UNFPA, at the country level in particular, had a leverage effect on WHO's technical and policy collaboration with countries in support of sexual and reproductive health.

Impediments

- Severe funding shortages markedly impeded achievement of the results expected in the area of reproductive health, particularly those under the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction. For example, it was not possible to award any new research capacity-building grants in 2005. In addition, a number of countries reported shortages of human and financial resources for delivering expected results in sexual and reproductive health.
- Cultural, political and other sensitivities regarding certain aspects of the sexual and reproductive health agenda, such as adolescent sexuality and issues related to preventing unsafe abortion, often necessitate extended planning, consensus building and methodological adaptation of proposed approaches, all of which may extend the time frame of activities.

Lessons learnt in 2004-2005 and how they will be applied in 2006-2007

- The need for effective structures to efficiently involve community organizations and men's groups is now widely recognized; for 2006-2007 an Organization-wide expected result has therefore been explicitly included involving individual, family and community actions for reproductive and sexual health.
- Inadequate supplies and unaffordable prices for reproductive health commodities remain a critical challenge. Interagency work on reproductive health commodity security will address this issue in 2006-2007.
- In order to monitor progress in achieving the Millennium Development Goals and other international development goals related to sexual and reproductive health, existing information systems need to be strengthened and expanded.

Approved budget and actual expenditure

		Approved budget	Actual expenditure		
			Regular budget	Other sources	All funds
Total 2004-2005 (US$ thousand)		67 070	7 218	55 081	62 299
Percentage	countries	19	27	8	10
	regions	7	28	5	8
	global	74	45	87	82

MAKING PREGNANCY SAFER

WHO objective(s)

To provide support to Member States and the international community in elaborating and implementing cost-effective interventions to make pregnancy safer.

Indicator(s) and achievement

Number of countries receiving technical and policy support to review or formulate comprehensive policies and programmes for reduction of maternal and perinatal mortality and morbidity: 39

Main achievements

- Evidence-based norms and tools, including planning and programming guidelines, were developed for maternal and newborn health.
- Information and advocacy activities were initiated at global, regional and national levels to increase government commitment to invest in and develop strategies to improve maternal and newborn health.
- Management and service-delivery capacity was increased at the community, primary and referral levels of the health systems in the priority countries through capacity building, workshops and direct technical support to countries.
- Information systems were strengthened to monitor progress in improving quality of care and to support attainment of the United Nations Millennium Development Goal of improving maternal health.
- The capacity of women, families and communities for improving maternal and newborn health was further strengthened through the development of relevant tools and the provision of technical support to countries.
- Partnerships within the international community and with global and regional development partners were strengthened, especially in relation to programmes in priority countries.
- Technical support was provided to improve emergency maternal and newborn health care during the emergency and rehabilitation phases in countries affected by the tsunamis and earthquakes (India, Indonesia, Maldives, Pakistan and Sri Lanka).
- Collaboration was strengthened with areas of work and related programmes including those on HIV/AIDS, malaria, nutrition, health systems, child and adolescent health, and other aspects of reproductive health.

Illustration of selected achievements

The guidelines and tools to support maternal and newborn health care, developed at headquarters, were translated or adapted by the regions and priority countries. National trainers were trained in the use of the guidelines and tools in several priority and other countries. Mongolia further developed one of the tools[1] into a distance-training course to increase numbers of trained personnel in essential obstetric care. Adaptation and implementation of evidence-based norms, standards and tools for maternal and newborn health services were also carried out in Democratic People's Republic of Korea, India, Myanmar, Thailand and Timor-Leste. Bangladesh, India, Indonesia, Myanmar and Nepal reviewed maternal/perinatal mortality. In 24 countries in the African Region, interventions to prevent transmission of HIV from mother to child, including increased access to paediatric HIV care and treatment, were introduced or extended. Four countries (Cameroon, Côte d'Ivoire, Malawi and Rwanda) reviewed prevention programmes with a view to scaling up such interventions. The Republic of Moldova implemented an evidence-based strategy for making pregnancy safer through a national workshop involving key stakeholders and partners and subsequently provided regular technical support in various areas. In coordination with UNICEF and UNFPA, the Regional Office for the Eastern Mediterranean provided technical support and conducted an inter-country workshop in Beirut on promoting evidence-based maternal and neonatal health norms and guidelines in the Arab countries.

[1] *Pregnancy, childbirth, postpartum and newborn care: a guide for essential practice.* Geneva, World Health Organization, 2003.

Achievement of Organization-wide expected results

Technical and policy support provided to countries for formulating and implementing cost-effective gender-sensitive national plans of action for making pregnancy safer that include information and services for evidence-based, good-quality maternal and newborn care and which respect women's rights

Indicator	Baseline	Target	Achievement
Number of countries receiving technical and policy support for maternal and newborn health	10	20	39

Thirty-nine developing countries received combined technical support from headquarters and regional offices, including development of context-specific evidence-based strategies and road maps to reduce maternal and newborn mortality, thus contributing towards the achievement of the Millennium Development Goals. Support to countries was coordinated and conducted in collaboration with development partners, UNICEF, UNFPA, the World Bank, other bilateral donors, nongovernmental organizations and professional bodies.

Appropriate evidence-based guidelines adapted and introduced in national policies, strategies, programmes and standards for maternal and newborn care, family planning and post-abortion care

Indicator	Baseline	Target	Achievement
Number of countries receiving support to adapt and introduce standards, guidelines and/or tools recommended by WHO	15	30	52

Most of the norms and guidelines developed at headquarters were translated into official United Nations languages and into other languages. In addition to widely disseminating guidelines and conducting regional workshops, dedicated and sustained technical support was provided by headquarters and regional offices for adaptation and utilization of the guidelines in order to improve evidence-based practices. In collaboration with UNFPA, WHO worked at regional and country levels to support adaptation and utilization of these evidence-based guidelines and tools.

Adequate support provided to countries for strengthening health systems interventions and management so that information and services for maternal and newborn health are made available, accessible and acceptable to all, especially to those from poor and disadvantaged communities

Indicator	Baseline	Target	Achievement
Number of countries that have received support to design, implement and evaluate health systems interventions to improve maternal and newborn health	5	15	20

Headquarters and regional offices provided technical support to countries in assessing human resource requirements and planning in the area of maternal and newborn health. Technical support was provided for district-level costing of increased interventions to reduce maternal and newborn mortality. In Africa the regional road map for the reduction of maternal and newborn mortality, mainly a health systems approach, was adopted and adapted by 24 countries. In almost all regions, support was provided in programme monitoring and improving quality of care by reviews of maternal mortality.

Success factors and impediments

Success factors

- Timely development and availability of relevant norms and guidelines.
- Establishment of effective mechanisms for coordinated and timely support to countries.
- Dedication of staff.

Impediments

- Declining commitment and support for maternal and newborn health at national and international levels and among donors.
- Inadequate technical capacity at regional and country levels.
- Poor health-system capacity with decreasing human resource skills and inadequate supplies and logistics.

Lessons learnt in 2004-2005 and how they will be applied in 2006-2007

- WHO's regional and country technical capacity must be improved, at least in priority countries, to provide urgently-needed and timely support. Trained national programme officers will therefore be placed in 10 to 15 priority countries in 2006-2007.
- Joint planning between all levels of the Organization must be strengthened to enhance and sustain coordination with and support to Member States. Timely programme implementation and technical support to countries must therefore be provided in 2006-2007, while operational planning for 2008-2009 will have to be initiated early to ensure Organization-wide coordination of plans.
- Advocacy is crucial for the Making Pregnancy Safer Initiative to succeed. In 2006-2007 an effective advocacy campaign must be developed at all levels, including direct contact with and briefing of media contacts to encourage increased commitment and investment.
- Interdepartmental collaboration and coordination has been less than optimal. In order to rectify this, working groups will be established in 2006-2007 to consider what might be achieved in collaboration with other areas of work, such as malaria, child and adolescent health, HIV/AIDS, nutrition, and in relation to health systems development and other aspects of reproductive health, with due regard for the need to avoid duplication of effort.

Approved budget and actual expenditure

		Approved budget	Actual expenditure		
			Regular budget	Other sources	All funds
Total 2004-2005 (US$ thousand)		38 711	12 370	10 503	22 873
Percentage	countries	51	59	2	33
	regions	16	31	26	29
	global	33	10	72	38

WOMEN'S HEALTH

WHO objective(s)

To support Member States in the development of policies, strategies and interventions that effectively address high-priority and neglected health issues of women throughout the life span, and in the creation of a body of evidence on the impact of gender on health and of tools, norms and standards to improve gender responsiveness of health interventions and promote gender equity in health.

Indicator(s) and achievement

Increase in financial and human resources devoted to issues of women's health and incorporation of gender considerations throughout the work of WHO. The receipt of specified funding for HIV/AIDS triggered an increase in the allocation of financial resources at headquarters, whereas in the regional offices financial and human resources remained inadequate. Despite an increase in gender-related work as a result of the WHO gender policy, it appears that gender mainstreaming is not yet systematically integrated into the Organization's work.

Main achievements

- A landmark report on women's health and domestic violence against women was launched and a linked training manual completed.[1] The study includes data obtained from more than 24 000 women in 10 countries.
- A new initiative documenting and highlighting the role of men in promoting gender equality in health was launched at headquarters as part of an effort to achieve health equity by promoting equality between women and men.
- Headquarters hosted the Sexual Violence Research Initiative in order to promote action-oriented research to reduce and respond to sexual violence.
- During the biennium, the scope and designation of the area of work, as well as of the department itself, evolved from focusing solely on women's health to encompass a broader gender-equality approach. At PAHO, the unit concerned was also renamed and placed directly under the Office of the Assistant Director, significantly improving its strategic positioning in the Organization. The PAHO Gender Equality Policy was adopted by the 46th Directing Council of PAHO in September 2005.[2]
- In May 2005, the Executive Board requested that a draft strategy and plan of action for incorporating a gender perspective into WHO's work should be submitted to the Executive Board at its 117th session.[3]

Illustration of selected achievements

As a result of the attention paid to women's health by the regional offices during the biennium, several tangible results were achieved including evaluation of a regional plan for the elimination of female genital mutilation in the African Region and a series of follow-up activities in prevention and management; the compiling of case studies on gender and health policy in seven countries in the European Region; the integration of gender into medical education in India, Nepal and Thailand in the South-East Asia Region; and the holding of a consultation on gender, health and religion in the Eastern Mediterranean Region.

Achievement of Organization-wide expected results

Standards, training modules, information tools and guidelines on specific women's health issues updated or produced and used to support regions and countries in the formulation and implementation of policies and programmes and in monitoring progress

Indicator	Baseline	Target	Achievement
Number of relevant documents (standards, training modules, information tools and guidelines) produced or updated	0	12	24
Proportion of regions and targeted countries having used or adapted those	0	Not established	10%

[1] *WHO Multi-country Study on Women's Health and Domestic Violence.* Geneva, World Health Organization, 2005.

[2] Resolution CD46.R16.

[3] Document EB116/2005/REC/1, summary record of the second meeting.

Indicator	Baseline	Target	Achievement
instruments in developing or implementing policies or programmes			
Number of countries systematically monitoring women's health	0	24	25

Various standards, training modules, information tools and guidance materials for specific women's health issues were produced during the biennium. These included materials on sexual and gender-based violence, female genital mutilation, sexual and reproductive health and rights, women in crisis, health sector reforms, education of health professionals, health indicators, and integrating gender considerations into the mainstream of health research focusing on mental health, lung cancer and tuberculosis. Regions reported that many of the above materials are actively and visibly used in countries to inform policy and programme development. Few, if any, countries systematically monitor women's health, although some report core health indicators that are disaggregated by sex.

Evidence-based reviews and collection of new data on the impact of gender on health and on specific women's health issues carried out by WHO, with information so generated disseminated and applied in advocacy and policy

Indicator	Baseline	Target	Achievement
Number of projects initiated, providing evidence on the impact of gender on various aspects of health	0	5	14
Number of products developed and activities undertaken to disseminate results to regions and countries and to professional and general audiences	0	40	47

The production of evidence on the impact of gender on various aspects of health has been a core function in women's health, especially at headquarters level. The purpose of this evidence is to convince audiences that gender inequality affects risk, health status, health-seeking behaviour and access to care. The multi-country study on women's health and domestic violence was an important achievement in this regard, as were the gender and health profiles compiled in a number of countries. Other initiatives and activities carried out included: the preparation of a biennial statistical brochure by PAHO;[1] the organization of a regional workshop on gender and rights in relation to reproductive and maternal health by the Regional Office for the Western Pacific; and the preparation at headquarters of a series on gender and health research in relation to tuberculosis, lung cancer and mental health. This series was devised to address the main issues involved in integrating gender considerations into health research.

Tools and guidelines developed and processes in place to facilitate incorporation of gender considerations in the technical work of WHO

Indicator	Baseline	Target	Achievement
Number of tools for gender analysis and centring gender considerations in technical work produced, tested and in use	0	Not established	4
Proportion of WHO's high-priority programmes using the tools developed	0	Not established	Proportion not known

Progress was made in the production of gender analysis and planning tools for WHO staff and national counterparts. In the Eastern Mediterranean Region, results-based management training materials to support operational planning were revised to include a focus on gender analysis and planning, and to reflect the expectation that such materials might be shared with other regions. Gender considerations have also been integrated into various documents in other technical areas at global and regional levels.

[1] *Gender, Health, and Development in the Americas. Basic Indicators 2005*. Washington, Pan American Health Organization, 2005.

New initiatives incorporating gender perspectives in technical programmes undertaken, with results and analyses documented and disseminated

Indicator	Baseline	Target	Achievement
Numbers of technical programmes, regions and countries launching initiatives incorporating gender perspectives in their work on a regular basis	0	Not established	38
Number of reports, leaflets and other materials produced at regional, country and global levels documenting those initiatives	0	40	36
Number of workshops and other meetings to exchange findings with different audiences	0	15	19

Considerations of gender, especially those relating to violence and mainstreaming, are now being integrated into the work of other technical programmes and cross-cutting functions of WHO and governments, such as health statistics. Regional reports indicate that gender focal points have proactively responded to help integrate a gender perspective into WHO's work through meetings, workshops, publications and country activities.

Success factors and impediments

Success factors

- The political commitment of Member States as demonstrated through: the recognition of the importance of gender equality and women's empowerment in achievement of the health-related Millennium Development Goals; support at the 2005 high-level plenary meeting of the United Nations General Assembly for asking the United Nations Secretary-General to request the heads of all United Nations agencies to contribute to the development of a strategy to integrate gender-consideration throughout the system; the Health Assembly's resolution WHA58.30 on accelerating achievement of the health-related Millennium Development Goals, which requested Member States to ensure that health and development policies are underpinned by a gender analysis and to strive for gender equality and women's empowerment.
- The existence of partnerships and networks in all regions with shared values and common goals that bring together actors from government, civil society, development partners and other United Nations entities. Documented examples of this include: the preparation of a joint work plan by six African Union regional bodies; strategic alliances with key regional organizations, nongovernmental organizations, other United Nations agencies and the Inter-American System in the Region of the Americas; and collaboration with a broad range of other United Nations agencies and actors at headquarters.

Impediments

- Commitment and support for gender integration within WHO has still not been fully achieved. Shared responsibility with accountability at the highest levels of the Organization is still missing. Gender is frequently treated as a discipline or a vertical programme rather than an approach to improve efficiency, which must be integrated across the Organization.
- There is a communication gap and limited awareness and skills in gender analysis and planning among WHO staff. There are also inadequate human and financial resources at all levels.

Lessons learnt in 2004-2005 and how they will be applied in 2006-2007

- Fostering commitment from technical programmes is not possible in the absence of accountability. Shifting the responsibility for gender integration to senior managers across WHO units at all levels will be the key to success in this regard. Therefore, the aim will be to create institutional accountability mechanisms for gender integration.
- Resource mobilization efforts are required to ensure the availability of adequate human and financial resources at all levels of the Organization. Work will be undertaken to increase staff capacity in regional offices, particularly in the Regional Offices for Europe, the Eastern Mediterranean and the Western Pacific.

Approved budget and actual expenditure

		Approved budget	Actual expenditure		
			Regular budget	Other sources	All funds
Total 2004-2005 (US$ thousand)		15 094	3 301	5 283	8 583
Percentage	countries	23	26	5	13
	regions	20	30	13	20
	global	57	44	82	67

HIV/AIDS

WHO objective(s)

To support the implementation, integration and intensification of essential health sector interventions against HIV/AIDS in countries and communities.

Indicator(s) and achievement

Increase in the number of targeted countries demonstrating competence and capability across the health sector to tackle HIV/AIDS. Technical support to more than 120 countries resulted in a substantial improvement in the number of countries able to demonstrate levels of competence and capability to tackle HIV/AIDS across the health sector.

Main achievements

- The "3 by 5" strategy, launched by WHO and UNAIDS in December 2003, was welcomed in May 2004 by the Health Assembly.[1] Global efforts to expand access to life-saving antiretroviral treatment increased significantly as a result of the "3 by 5" initiative, with substantial gains in the numbers of people receiving the treatment in every region of the world. From a baseline of about 400 000 people on antiretroviral treatment in low- and middle-income countries in December 2003, about 1.3 million people were receiving treatment by December 2005.
- As part of the global effort to achieve the "3 by 5" target, WHO provided technical support to more than 100 countries to help strengthen national responses, including the development of national scale-up plans, training health personnel, increasing the availability and uptake of HIV counselling and testing, strengthening systems to procure and supply medicines and diagnostics and implementing simplified treatment guidelines and regimens consistent with a public health approach.
- The "3 by 5" initiative has required the mobilization of a global partnership to extend treatment and accelerate HIV prevention. By the end of 2005, more than 200 partner organizations were working with WHO or otherwise contributing to the attainment of the "3 by 5" target. These included the AIDS Medicines and Diagnostics Service, a major partnership of 15 organizations assisting governments and nongovernmental organizations to build local capacity in procurement and supply management for essential medicines, including antiretroviral medications.
- To ensure that medicines meet international manufacturing and safety standards, WHO strengthened its prequalification project; and it maintains and updates the essential medicines list. WHO also hosts the secretariat for the HIV Resistance Network, a global network of laboratories that will monitor HIV drug resistance.
- WHO has worked in at least 29 countries to support the adoption of the Integrated Management of Adult and Adolescent Illness approach to health and community worker training. That approach provides short, efficient training courses that teach health-care workers the essential skills and knowledge to deliver antiretroviral treatment and support the task shifting necessary, not just for treatment scale-up, but for chronic care in general.
- The "3 by 5" effort has helped to establish that antiretroviral treatment is feasible and affordable in resource-limited settings, and has paved the way for further scale-up towards universal access to treatment by 2010. The scale-up of antiretroviral treatment has also highlighted the need to simultaneously accelerate HIV prevention efforts, particularly in the health sector, and to ensure that the opportunities created by the expansion of HIV/AIDS interventions contribute to the overall strengthening of health systems.

Illustration of selected achievements

During the biennium one of the key achievements was the capacity strengthening of WHO country offices. This included the international recruitment of 39 "3 by 5" HIV country officers: 22 based in the African Region, three in the Region of the Americas, four in the South-East Asia Region, three in the European Region, four in the Eastern Mediterranean Region, and three in the Western Pacific Region. In addition, the number of national and other professional staff increased to at least 80. In 56 countries procurement and supply management was strengthened through planning workshops conducted in collaboration with various partners. Examples are the PAHO consolidation of the Regional Revolving Fund for Strategic Public Health Supplies. This fund facilitated the acquisition of more than US$ 5 million worth of antiretroviral agents and the development of procurement plans in seven countries.

[1] Resolution WHA57.14.

Achievement of Organization-wide expected results

Normative guidance developed and provided to countries to enhance essential HIV prevention, treatment, care and support services and interventions

Indicator	Baseline	Target	Achievement
Number of targeted countries using and/or adapting WHO tools on management of HIV and related conditions including tuberculosis and sexually transmitted infections, and on the procurement, manufacture, regulation and appropriate use of HIV-related drugs and diagnostics	26	50	95

Within the African Region 25 Member States adapted or applied WHO treatment guidelines and toolkits, and 16 implemented in full the essential package of HIV/AIDS interventions. The Regional Office for the Americas supported the development and adaptation of a wide range of guidelines and toolkits, such as the development of Caribbean guidelines for voluntary HIV counselling and testing, and guidelines to support HIV care and treatment with a public health approach. At least four Member States implemented interventions to decentralize antiretroviral treatment following WHO guidelines. Seven Member States were supported in developing acquisition plans and improving their supply and distribution facilities. An assessment of their medicines policy, focusing on generic medicines regulation, was completed in 14 Member States and antiretroviral supply systems were assessed in two. Nine Member States were supported in reviewing their national norms and protocols for sexually transmitted infections control, and a regional adaptation of WHO HIV testing guidelines was completed. A new youth-centred counselling model was piloted and is being implemented in seven countries; four countries are receiving support from the regional office to develop national plans and/or operational plans for scaling up prevention of mother-to-child transmission of HIV. The Regional Office for South-East Asia saw the development and adaptation of a wide range of training packages for countries, for example in counselling and testing, harm reduction and laboratory diagnosis of HIV and opportunistic infections. In the Regional Office for Europe, treatment and care protocols (including antiretroviral treatment for injecting drug users) for countries of the Commonwealth of Independent States were developed, updated and expanded so as to be relevant for the whole European Region. In collaboration with national counterparts, the regional office prepared strategy papers developing price reduction options for antiretrovirals for Commonwealth of Independent States countries. The Regional Office for the Eastern Mediterranean adapted Integrated Management of Adult and Adolescent Illness materials for use in Sudan, and antiretroviral treatment guidelines for use in Djibouti. The Regional Office for the Western Pacific extended the use of Integrated Management of Adult and Adolescent Illness guidelines in three Member States and WHO model treatment and care guidelines in six. Headquarters supported the regional offices by generating 55 normative guidelines and tools for dissemination, in addition to integrated capacity building materials.

More comprehensive and reliable national and global mechanisms for HIV surveillance, monitoring and evaluation formulated or in place

Indicator	Baseline	Target	Achievement
Number of targeted countries that conduct surveillance studies in identified priority populations, including surveillance of behaviour and antiretroviral resistance patterns	88	130	143
Number of evidence-based reviews to support strategies	132	220	246

Within the African Region the number of Member States appropriately applying guidelines for second generation HIV surveillance increased from two to 20. The Regional Office for the Americas focused its efforts on building country capacity for monitoring and evaluation. Regional and national workshops were conducted and monitoring and evaluation visits were supported in at least four Member States in collaboration with other partners. Also in collaboration with other partners, a surveillance plan was developed for the Central American region and five countries developed national surveillance plans. An epidemiology network provided horizontal technical cooperation in the area of monitoring and evaluation, including surveillance. PAHO coordinated at least seven intercountry exchanges. The Regional Office for Europe carried out regular region-wide surveillance of sexually transmitted infections, HIV and AIDS in all 52 Member States, and epidemiological fact sheets and regional and country-specific antiretroviral needs and coverage estimates for all 52 Member States were updated. A knowledge

hub on second-generation surveillance was established in Croatia and this provided a series of regional training programmes. The Regional Office for the Eastern Mediterranean concentrated on regional training in second-generation HIV/AIDS surveillance for all Eastern Mediterranean Region countries. The regional office also provided technical support for second-generation HIV/AIDS surveillance to the Islamic Republic of Iran, Pakistan and Yemen, and in collaboration with Family Health International, started to train national teams in Member States of the Region. The Regional Office for South-East Asia established second-generation surveillance systems, including integrated HIV/AIDS, sexually transmitted infections and behaviour surveillance in almost all countries. The regional office was also able to initiate plans for HIV drug-resistance studies in countries where antiretroviral programmes are being expanded. Within the Western Pacific Region, extensive Member State involvement was achieved in HIV/AIDS, sexually transmitted infections and behaviour surveys. Efforts at headquarters focused on the development of an HIV drug-resistance framework and protocol, global antiretroviral medicine pricing issues, procurement and supply management assessment at country level, and monitoring reports on treatment scale-up in countries.

Dynamic and relevant global agenda and innovative partnerships stimulated for research, including vaccine and microbicide development and operations research

Indicator	Baseline	Target	Achievement
Number of research initiatives strengthened through WHO mechanisms	7	17	24

The Regional Office for Africa strengthened one research initiative, through the African AIDS Vaccine Programme. The Regional Office for the Americas supported multicentric research studies on sexual behaviour among high-risk groups in Central America and the Caribbean. The Regional Office for South-East Asia organized an informal regional consultation on operational research on scaling up care and treatment, and this led to WHO supporting two research studies in the region. The Regional Office for the Eastern Mediterranean was able to support 12 research studies. The Regional Office for the Western Pacific instigated a study on human herpes virus 2 and HIV. The HIV/AIDS department at headquarters, in collaboration with the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases, was able to initiate a series of operational research studies in three countries in the African Region.

HIV/AIDS advocacy and strategic planning enhanced through the promotion and development of multisectoral partnerships

Indicator	Baseline	Target	Achievement
Number of countries incorporating recommendations of the global health sector strategy into national plans	40	60	80
Number of strategic collaborations and partnerships supported by WHO	10	200	210

The Regional Office for Africa was able to support the development of national plans for health sector response to HIV/AIDS for nine countries, and establish two subregional partnership forums for the east and southern African and west and central African areas. The Regional Office for the Americas launched a regional Plan for HIV and sexually transmitted infections for the health sector 2006-2015 in November 2005. This embraces a health-sector strategy to achieve universal access to prevention, care and treatment. Two regional meetings of the Technical Advisory Committee were conducted with a broad range of partners, including national AIDS programmes coordinators, international partners, youth representatives and representatives of civil society, people living with HIV, and PAHO/WHO staff. Nearly all 24 Latin America and Caribbean reporting countries produced a national policy on antiretroviral treatment access and national-level actions towards improving services in the region. In 2005, with support from "3 by 5" initiative, two countries (Guatemala and Guyana) developed national strategic plans for 2006-2010. In the Eastern Mediterranean Region, 15 countries developed a national AIDS programme as a priority, and all countries in the region intensified public information and health promotion activities for HIV/AIDS using mass media and other communication channels. The Regional Office for Europe strengthened, developed and maintained active partnerships with at least five entities, and technical and funding partnerships were developed and maintained with aid agencies and several European governments. All countries in the South-East Asia Region incorporated recommendations of the global health-sector strategy into their national plans, and three countries received direct technical support to develop national plans. In the Western Pacific Region, five countries included global health-sector strategy components in their national plans, as well as country-level partnerships with various aid agencies. The headquarters contribution consisted in coordinating, developing, and sustaining a global advocacy and communications strategy around "3 by 5", to ensure that WHO visibility at key events was assured, and to seek out financial resources to fund the largely unfunded HIV/AIDS area of work.

Countries supported to build national capabilities and technical expertise for improving health system responses to HIV/AIDS and sexually transmitted infections, including planning, resource allocation, delivery and evaluation of services and interventions

Indicator	Baseline	Target	Achievement
Number of targeted countries building health-sector competences in HIV/AIDS, including uptake of WHO normative tools and resources	30	60	73
Number of countries accessing Global Fund to Fight AIDS, Tuberculosis and Malaria and/or other donor support with WHO technical assistance	20	50	55

The introduction of Integrated Management of Adult and Adolescent Illness within 19 African countries was effected in collaboration with the Regional Office for Africa and the HIV/AIDS department at headquarters. During the biennium, technical assistance was given to 15 countries to facilitate access to and utilization of the Global Fund to Fight AIDS, Tuberculosis and Malaria funding opportunities in the African Region. The Regional Office for the Americas provided support to many countries for Global Fund to Fight AIDS, Tuberculosis and Malaria project development and problem solving processes, including a workshop for five countries which received new grants in 2005. High priority was given to human resource development and 18 countries conducted training for health personnel. The process for the adaptation of the Integrated Management of Adult and Adolescent Illness for Latin America and the Caribbean was initiated; Haiti conducted a national workshop to adapt the tool. Several countries also benefited from PAHO/WHO support to develop existing services as entry points for prevention, care and treatment of HIV and Belize, Honduras and Nicaragua undertook projects to foster the linkages of HIV and domestic violence services. About half the Member States in the Eastern Mediterranean Region now have a standardized protocol on antiretroviral treatment for people living with HIV/AIDS, and 19 out of the 21 Member States in the region had instated 100% safe blood and infection control. The Regional Office for Europe focused its efforts on developing national treatment scale-up plans, prevention, treatment and care guidelines, development and implementation of Global Fund to Fight AIDS, Tuberculosis and Malaria projects, and increasing the capacity of the health sector in countries. This was achieved by WHO's build-up of direct technical assistance in countries across the region. Training tools developed by the Regional Office for South-East Asia allowed health sector competences to be built in all 11 Member States of the region. The tools covered a wide range of topics, for example, voluntary testing and counselling, clinical management, antiretroviral treatment, Integrated Management of Adult and Adolescent Illness, tuberculosis/HIV, nursing, midwifery, laboratory and surveillance. Technical assistance to three countries was also provided in relation to grant submissions to the Global Fund. The Regional Office for the Western Pacific also assisted countries with submissions to the Global Fund, seven of which saw their HIV component proposals approved for funding. Headquarters focused its efforts on providing punctual technical assistance at regional and country level, upon request, and in facilitating and accelerating "3 by 5" officer recruitment at country-office level.

Success factors and impediments

Success factors

- Strengthened WHO regional- and country-office presence allowing for improved technical assistance.
- Sufficient resources to enhance technical support at regional and country levels.
- Extensive use of partnerships, coordination and cooperation with a wide range of interested parties.
- Clear focus on WHO's expected results in relation to the treatment and care of HIV/AIDS, using a public health approach.
- Political commitment and country efforts allowing for synergy between WHO, national health authorities and national stakeholders.
- Priority and support given to HIV/AIDS at the highest management level of the Secretariat.
- Inter-programmatic approach and harmonization of various levels (country, subregional, regional and global).

Impediments

- The urgent need to strengthen country health systems and human resources.
- Prevailing stigmatization and discrimination in health programmes and services at all levels and in the community remain a major barrier to universal access to HIV services.
- A lack of coordination, particularly at country level, in matching recruitment and an appropriately phased introduction of WHO expertise to the rapid growth in financial resources, especially in 2005.
- Procurement and supply management issues relating to HIV medicines.

Lessons learnt in 2004-2005 and how they will be applied in 2006-2007

- The "3 by 5" target had an important catalysing effect at global level and has been acknowledged as an important step in a longer-term global effort to realize the objectives set out in the health-related Millennium Development Goals. It has demonstrated that providing treatment is possible even in the most resource-challenged settings, but both sound planning and well-supported infrastructures are essential. Perhaps most importantly, it illustrates that expanded international financial support, improved international coordination and communication, clear indicators and targets, robust monitoring and evaluation, enhanced partnership structures, improved implementation of lessons learnt, and an intensified focus on strengthening health systems are all essential elements in achieving universal access by 2010. It has highlighted the importance of using existing opportunities and health infrastructures to deliver antiretroviral treatment and scale up HIV prevention in resource-limited settings, notably in the areas of tuberculosis, sexual and reproductive health, prevention of mother-to-child transmission of HIV and management of substance dependence.
- The benefits of WHO regional- and country-level technical expertise will need to be maintained, and further strengthened in some regions, in order to maintain the momentum of the results achieved in 2004-2005.
- Mobilizing resources to maintain and further strengthen the WHO programme of work for HIV/AIDS in the medium to long term remains a major challenge. In 2004-2005, the "3 by 5" initiative derived considerable benefit from a grant of Can$ 100 million, the largest single grant ever received by WHO. Maintaining the momentum generated towards improving WHO's ability to respond effectively in the treatment, prevention and care of HIV/AIDS during 2006-2007 will depend on adequate new financial resources being received during the biennium.

Approved budget and actual expenditure

		Approved budget	Actual expenditure		
			Regular budget	Other sources	All funds
Total 2004-2005 (US$ thousand)		218 116	15 462	110 644	126 106
Percentage	countries	65	34	42	41
	regions	22	34	22	24
	global	13	32	36	35

SUSTAINABLE DEVELOPMENT

WHO objective(s)

To ensure that health has a central role in reducing poverty internationally and nationally and development policies and practices (including their economic, social, environmental and trade components).

Indicator(s) and achievement

Increase in allocations to health both in absolute terms and as a proportion of financing for development assistance. Major commitments to increase overall funding for development were made in 2005. Development assistance for health increased as a proportion of overall aid during the biennium; the Organization's advice, advocacy and analysis played a significant role in bringing this about.

Overall increase in national allocations to health in developing countries. Developing countries were actively supported in the process of increasing investment in health through the elaboration of Poverty Reduction Strategy Papers and medium-term expenditure frameworks, Global Health Partnerships and implementation of the recommendations contained in the report of the Commission on Macroeconomics and Health.

Main achievements

- The High-Level Forum on the Health MDGs helped to achieve a consensus on how to overcome the major constraints impeding country-level scale up in relation to the quantity and quality of aid for health, health systems and human resources, the role of global health partnerships and the special circumstances of fragile States. The challenge now is to translate this consensus into action at country level.
- WHO developed a United Nations-wide policy on sector-wide approaches and led the United Nations group at the Second High-Level Forum on Aid Effectiveness, (Paris, 28 February to 2 March 2005), where global health partnerships received special attention. Work continued on monitoring how health is reflected in national poverty reduction strategies, and new work on the role of health, human rights and poverty reduction was well received. Much of this work has been incorporated into online training courses.
- Health issues featured prominently in the outcome of the 2005 World Summit of the United Nations General Assembly to review progress in fulfillment of commitments contained in the United Nations Millennium Declaration.
- A wide range of country work was undertaken to promote the Millennium Development Goals. WHO's relationships with regional institutions such as the New Partnership for Africa's Development were also useful for advocating a more prominent place for health in national policies and plans.

Illustration of selected achievements

The Regional Committee for Africa adopted a resolution on achieving the health Millennium Development Goals in the African Region;[1] participants in the panel discussion conducted in parallel with the Regional Committee meeting also considered how to tackle the social determinants of health and health inequalities. A team with a sustainable development component was formed to coordinate planning between the three levels of WHO. The aim was to provide an initial group of 13 countries with support to achieve universal health-care access and coverage as a main element of WHO's 2006-2007 strategy for supporting Member States in the Region in their attainment of the Millennium Development Goals. Efforts were also made to align streams of work underlying the Goals to ensure coherence in health development planning. The following areas were concerned: the social determinants of health, human rights, poverty and health and planning for health development through processes such as sector-wide approaches, medium-term expenditure frameworks, Poverty Reduction Strategy Papers and planning in relation to the Millennium Development Goals. In particular, the work on the social determinants of health being carried out in Kenya promises to provide a means of demonstrating to other countries how health outcomes can be achieved more effectively by tackling the determinants of health upstream, as well as how such an approach can be integrated into planning frameworks and cycles.

[1] Resolution AFR/RC55/R2.

Achievement of Organization-wide expected results

Enhanced capability in WHO at country, regional and global levels, and in Member States, especially the least developed countries, to shape the health content of national poverty-reduction strategies, including poverty-reduction strategy papers

Indicator	Baseline	Target	Achievement
Independent evaluation and approval of health content of Poverty Reduction Strategy Papers	23 Poverty Reduction Strategy Papers reviewed	20 additional Poverty Reduction Strategy Papers reviewed	15 reviews of Poverty Reduction Strategy Papers were conducted
Application of training and communication tools, mechanisms and programmes in building capability of WHO and national and development agency partners	Negligible application of tools, mechanisms and programmes is in place	Increase in take up and application of tools	Over 150 staff from WHO and national and development agencies successfully completed the World Bank/WHO course

WHO's programme of work on monitoring the place of health in Poverty Reduction Strategy Papers continued during the biennium and the WHO database on health in Poverty Reduction Strategy Papers was brought up to date. In particular, in 2001-2002 WHO contributed a health perspective to the IMF/World Bank comprehensive review of the Poverty Reduction Strategy Papers approach. Key findings for improving provision of support to countries concerned: strengthening the medium-term orientation of the Poverty Reduction Strategy Papers; enhancing linkages between the Strategy Papers, medium-term expenditure frameworks and budgets; broadening and deepening participation; utilizing the Strategy Papers as a mutual accountability framework for countries and donors; and tailoring the Poverty Reduction Strategy Papers approach to the needs of conflict-affected and fragile States. Regional offices provided support to Member States either to revise their poverty reduction strategy, including resource estimation, in order to formulate a health-sector medium-term expenditure framework, or to set up a national task force on macroeconomics and health and finalize and publish a national report on scaling up health investment for better health.[1] A donor-government mechanism for promoting political and financial commitment to health for socioeconomic development was put in place. In addition, key documents that will form the backbone of the training materials were commissioned and are under development. Training programmes and workshops were held for staff from WHO and national partners in order to ensure increased application of tools.

Programmes of capacity building implemented in Member States to protect and promote public health in the context of multilateral trade agreements

Indicator	Baseline	Target	Achievement
Analysis and preparation of strategic and policy responses to the public health impacts of accession to WTO and multilateral trade agreements by selected countries in each WHO region	Expert workshop on trade in health services and the General Agreement on Trade in Services held. Outcome of this to be followed up	Outcome of the workshop published, disseminated to WHO regions and countries and follow-up in progress on existing work	Interregional workshop held with regional participation supported by country missions. Additional requests for country missions pending due to financial constraints
Creation and updating of WHO web-based databases on evidence and indicators of links between globalization and health	Glossary and database exist	Glossary and database reflect up-to-date information	Regular updating of glossary and database reflect current status

Expert workshops on trade, health and globalization were held during the biennium and their findings published and presented in different forums. In collaboration with the communicable diseases department, studies were completed on the rapid assessment of the economic implications of global disease outbreaks. The Regional Offices for South-East Asia, the Eastern Mediterranean and the Western Pacific collaborated to hold an interregional workshop in New Delhi in October 2004, on developing national policy coherence and capacities in trade and health for countries in WTO accession. Sixty participants from

[1] *Scaling-up health investments for better health, economic growth and accelerated poverty reduction: final draft report of the Ghana Macroeconomics and Health Initiative*, Geneva, World Health Organization (in press).

health and trade ministries from 19 countries discussed how best to protect and promote health while their countries were involved in accession negotiations. Countries prepared drafts of national trade and health action plans for further discussion and development by existing or newly formed national trade and health working groups that include major governmental and nongovernmental stakeholders. A WHO technical working group on globalization, trade and health produced a Secretariat report on international trade and health that was considered by the Executive Board at its 116th session.[1] Two training courses on multilateral trade agreements and public health and health policy in a globalizing world were held at headquarters. In response to requests from Member States, trade and health country missions to Malaysia and Viet Nam were undertaken in 2004.

In collaboration with partner agencies, including organizations in the United Nations system, knowledge and good practice in health gains from intersectoral policy and practice shared with Member States in all WHO regions; areas of collaboration covered: employment, education, macroeconomic policy, environment, transport, nutrition, food security and housing

Indicator	Baseline	Target	Achievement
Application of health impact assessment tools in selected countries	Few health policies with investment plans linking strategies with financing and monitoring and evaluation	National cross-sectoral health and development mechanisms in place to develop health investment plans for input into formulation of sector strategies	About 13 countries established national cross-sectoral mechanisms that have resulted in country-led health and development analysis and, in some cases, investment plans with specific targets and costs, with linkages to other development processes
Number of WHO staff at country, regional and global levels trained in the application of cross-sectoral analysis, planning and decision-making processes in one or more areas of collaboration	A very limited number of trained staff at country and regional levels	At least one staff member in each regional office trained	Capacity development in regional offices supported by a network of experts. At least one network identified in each region to support macroeconomics and health focal point in regional office

Advocacy activities and situation assessments initiated in about 40 countries. The development of a toolkit on health impact assessment for local governments was completed, disseminated and began to be applied widely. Critical reviews of case studies and the scientific literature concerning healthy urban planning, physical activity and urban design were completed. A critical review of city health profiles across Europe was completed. Case studies on healthy ageing and health impact assessment were completed and presented. A set of indicators was developed and shared with the countries implementing the recommendations of the Commission on Macroeconomics and Health. Regional reports based on countries' progress towards implementation of the recommendations of the Commission on Macroeconomics and Health were developed. All countries in the Eastern Mediterranean Region endeavoured to identify potential partners in community-based initiatives; successful examples include: Afghanistan, Djibouti, Jordan, Islamic Republic of Iran, Morocco, Oman, Pakistan, Saudi Arabia, Sudan, Syrian Arab Republic and Yemen. WHO focal points in all six regional offices and numerous countries are supporting national macroeconomics and health mechanisms and other cross-sectoral processes.

Systematic monitoring and assessment by WHO of process, impact and health outcomes of poverty-reduction strategies, including progress towards Millennium Development Goals, established in all WHO regions

Advantage taken of new funding opportunities for health

Indicator	Baseline	Target	Achievement
Identifiable WHO influence on development and implementation of health and poverty-reduction strategies of partner institutions	Very limited WHO influence	Increased WHO influence on partner institution strategies	The World Bank and the European Commission collaborated in the High-Level Forum on the Health MDGs, and monitoring and partnership development for the Goals

[1] Document EB116/4.

Indicator	Baseline	Target	Achievement
Improved quality of grant applications to the Global Fund to Fight AIDS, Tuberculosis and Malaria due to WHO technical support to countries	Limited number of grant applications were of sufficient quality to obtain successful funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria	To provide technical support to at least 5 countries	Technical support was provided to 3 countries

In collaboration with the World Bank, WHO completed a series of meetings of the High-Level Forum on the Health MDGs, the third and final meeting of which was held in Paris in November 2005. Agreement was reached on the need to mobilize long-term, sustainable financing for the health sector, and on the paramount importance of increasing the predictability of development assistance for health. Discussions on the most suitable instruments for providing more predictable resources will continue in 2006. The European Commission was successfully engaged as a key partner in monitoring and partnership development for the Millennium Development Goals in eight countries in order to accelerate the Goals' achievement. The Fifty-eighth World Health Assembly adopted a resolution on accelerating achievement of the internationally agreed health-related development goals, including those contained in the Millennium Declaration.[1] In Niger, efforts were made to support a move towards a sector-wide approach to health development and a national health development plan based on the Goals. The first international knowledge forum on poverty and inequity in health took place in Paris in November 2004. A number of case studies on how health systems are confronting poverty have been identified and a publication will follow in 2006. WHO also provided support to Ethiopia, Kenya and Mozambique in applying for funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria.

WHO health and human-rights strategy developed and capability created in all WHO regions to provide technical support to Member States to integrate human rights in national health and poverty-reduction strategies

Indicator	Baseline	Target	Achievement
Inclusion of human rights in health and poverty-reduction strategies and plans in selected countries	Limited tools and capacity available at country level	Capacity built within WHO and among national partners to integrate human rights in health and poverty-reduction strategies and plans	Technical assistance provided to countries through the development of tools that integrate a rights-based approach in Poverty Reduction Strategy Papers in relation to health, the placement of staff in 3 Member States, and technical input to 17 WHO country cooperation strategies
Take up of WHO technical advice on health in human-rights assessments in selected countries in all WHO regions	Very limited evidence of take-up	Technical assistance for human-rights assessment in relation to health taken up by 6 countries	Technical assistance taken up by 2 countries. Full-time technical staff placed in only a few countries to support take-up of technical advice

An Organization-wide task force to guide the development of a WHO strategy on health and human rights held seven meetings in 2004-2005 and drafted an annotated outline strategy. The Regional Offices for South-East Asia and the Western Pacific held briefings for WHO Representatives on health and human rights. The Regional Office for the Eastern Mediterranean hosted an intercountry consultation on the draft health and human-rights strategy. The Regional Office for Europe issued its revised Health For All policy framework, integrating a human rights-based approach. The Organization-wide process of developing a WHO health and human-rights strategy, however, was not completed and it is unclear whether and how this will be taken forward in the light of resource and other constraints.

To build institutional capacity in health and human rights, focal points were established and are functioning at all regional offices. Regional offices have, moreover, established cross-cluster technical working groups. Three associate professional officers have been deployed in Mozambique, Uganda and Viet Nam to commence work on health and human rights at country level. Five

[1] Resolution WHA58.30.

training sessions have been conducted at country level and two at regional level, and several have taken place at headquarters and with partner institutions. Inputs on health and human rights were made to 17 country cooperation strategies. Training modules and tools, including a web-based long-distance learning tool on health and human rights, were also developed. In this context, a guidance document on operationalizing a human rights-based approach to health in the context of poverty-reduction strategies was widely disseminated, and consultations were initiated to further improve its practical application. Publications in the health and human rights series were further translated and disseminated (for example, the cartoon on HIV stigma was launched in four sub-Saharan African countries and one publication was issued in a tenth language).[1] A global work plan was developed with regional and country offices to strengthen WHO's work on indigenous health and human rights. Effective collaboration with the United Nations human rights system, in particular the human rights treaty bodies and the Special Rapporteur of the Commission on Human Rights on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, was taken forward, including in relation to the right to health indicators and treaty body reporting.

Success factors and impediments

Success factors

- Enhanced appreciation of interlinkages between health and poverty and between health and economic growth created a climate conducive to sustainable development and healthy environments.
- Growing global resources and an interest in and focus on health development pushed or attracted countries to move on health in sustainable development (for example, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Global Alliance for Vaccines and Immunization, the President's Emergency Plan for AIDS Relief (United States of America), the Bill and Melinda Gates Foundation, the Commission for Africa, and the Millennium Development Goals).
- A well-developed regional strategy aimed at strengthening the health component in community-based initiatives to ensure the poor have access to basic health-care services.
- The political commitment to poverty reduction and sustainable development shown by governments in some countries which placed health at the centre of the development and allocation of additional funds to improve the socioeconomic status of poor people.
- Partnership development and involvement of potential partners to support programme expansion.
- Continuous follow-up and direct contact with WHO Representatives' offices.
- Recognition of the importance of countries exchanging experiences.
- The availability of tested methodologies for work related to health systems in confronting poverty.

Impediments

- Insufficient intrasectoral collaboration between different health-related programmes.
- Insufficient political support at the national level for the institutionalization of community-based initiatives as part of national health and development policies and plans.
- High poverty levels in low-income countries combined with complex emergencies, insecurity and political conflicts in several countries.
- Funds allocated for poverty reduction are relatively low compared to the actual level of poverty.
- Weak health-care delivery systems and a lack of reliable information on poverty and health in low-income countries.
- Insufficient allocation of funds affects human resource planning and thus the implementation of planned activities.

Lessons learnt in 2004-2005 and how they will be applied in 2006-2007

- Additional resources allocated to improving the health of the poor represent an investment in development. In this regard, the role of governments in programme ownership is vital. Therefore, active collaboration with governments on this issue is one of the objectives for the next biennium. Close collaboration with and active involvement by representatives from ministries of finance, budget and planning are key factors in attaining programme sustainability and expansion. The country cooperation strategy is a central part of this collaboration process and active involvement in it is expected to be beneficial in the future.

[1] *25 questions and answers on health and human rights*. Geneva, World Health Organization, 2002.

- The leading role of WHO country offices, in collaboration with other United Nations agencies, nongovernmental organizations and potential health and development partners is essential to accelerate countries' ability to reduce poverty and achieve the Millennium Development Goals. Good partnerships with European Union institutions and the Council of Europe proved successful. For example, the health network established jointly by WHO and the Council of Europe had a notable impact and this work will be carried forward in the coming biennium.
- The importance of having an overall framework to facilitate priority actions, for example, regional committee recommendations on poverty and health, and work related to the Millennium Development Goals. Linkages between different initiatives and programmes related to health and development, such as Poverty Reduction Strategy Papers, sector-wide approaches and country cooperation strategies, will prevent duplication of efforts and will lead to a synergistic approach. These linkages should be further strengthened in collaboration with other global partners in 2006-2007.
- Evidence-based information and descriptions of success stories are important tools for gaining further support from policy-makers and high-level managers for programme expansion. It is important to have an established network such as that on healthy cities as many issues related to policy implementation in the areas of health, the environment and development are becoming a sub-national responsibility. Active continuation of such networks will be pursued in the coming biennium.

Approved budget and actual expenditure

		Approved budget	Actual expenditure		
			Regular budget	Other sources	All funds
Total 2004-2005 (US$ thousand)		28 840	15 144	15 864	31 008
Percentage	countries	46	43	20	32
	regions	22	26	32	29
	global	32	31	48	39

NUTRITION

WHO objective(s)

To provide Member States and the international community with authoritative technical guidance and collaborative support for improving their effectiveness in identifying, preventing, monitoring and reducing malnutrition and diet-related health problems, and in promoting healthy diet and nutrition.

Indicator(s) and achievement

Number, nature and scope of authoritative technical guidance drafted and disseminated for prevention, management and monitoring of malnutrition and promotion of healthy diet and nutrition. Five sets of technical guidelines on management and monitoring of malnutrition were drafted and disseminated. Training materials on management of infant feeding in emergencies were prepared and disseminated.

Number of Member States and international organizations that have collaborated with WHO in combating malnutrition and promoting healthy diet and nutrition. One hundred and eighty Member States and many international organizations collaborated with WHO in the development of strategies and surveillance programmes to combat malnutrition and promote healthy diets and nutrition.

Main achievements

- Work in the area of infant and young child nutrition was strengthened during the biennium. The first set of child growth standards was constructed and field tested and was ready for dissemination to Member States in early 2006. The new standards show that children from geographically diverse regions experience very similar growth patterns when their health needs are met. This establishes a single growth norm for children irrespective of background.
- In the area of micronutrients, expert consultations recommended the preparation of guidelines on prevention of iodine deficiency in pregnant women and young children, and control of folate and vitamin B12 deficiencies. Indicators to assess zinc and iron status were also identified. The World Health Assembly, in May 2005, adopted a resolution sustaining the elimination of iodine deficiency disorders.[1]
- Childhood obesity is now recognized as a major public health issue. Recommendations prepared at an expert meeting on prevention of the condition have led to the development of an international growth reference for school-age children and adolescents and school-based nutrition intervention programmes.
- The key role of nutrition in the achievement of nearly all the Millennium Development Goals has been clearly established. Undernutrition affects child mortality, maternal health and diseases such as HIV/AIDS and malaria, and has an affect on education and gender.
- Nutrition was also recognized as a key element in a comprehensive approach to HIV/AIDS and WHO's response to emergencies and crises during the biennium.
- Restructuring has taken place in the department to address under-nutrition and the growing double-burden arising from nutritional problems. Emphasis was placed on making stronger linkages between the programme areas to build an integrated and comprehensive nutrition agenda that addresses malnutrition from under- and over-nutrition throughout life. Strengthening collaboration with and between the regional offices was also treated as a priority.

Illustration of selected achievements

A technical consultation on nutrition and HIV/AIDS was convened in Durban, South Africa in April 2005. Experts on HIV/AIDS and nutrition, representatives from the most affected African countries, concerned nongovernmental organizations and international organizations agreed that there was now adequate scientific evidence and field experience to allow countries and the international community to incorporate nutritional strategies into HIV/AIDS treatment and care programmes worldwide. At the request of Member States, a draft resolution on nutrition and HIV/AIDS will be submitted to the Fifty-ninth World Health Assembly for its consideration.

[1] Resolution WHA58.24.

Achievement of Organization-wide expected results

Appropriate strategies formulated, and support provided, for sustainable reduction of malnutrition in its different forms; for improved infant and young child feeding; and for promotion of healthy dietary intakes, particularly in collaboration with FAO and through the Codex Alimentarius Commission

Indicator	Baseline	Target	Achievement
Number and proportion of targeted countries and regions that have developed strategies and programmes aimed at reducing major forms of malnutrition, and that are promoting appropriate dietary intakes	0	20	44 countries (220%)

The translation of global recommendations on promoting exclusive breastfeeding for six months and appropriate complementary feeding and continued breastfeeding into local action in 10 African Member States was encouraged by WHO and its partners, notably UNICEF. WHO also provided technical and financial support for action plans in these countries. The baby-friendly hospital initiative was revitalized. In addition to wide dissemination of a comprehensive monitoring and assessment guide, training materials have been revised and streamlined. Regional meetings held in Spain and Botswana to update global criteria and related assessment and training tools, provided opportunities for networking and obtaining feedback on the global strategy for infant and young child feeding and the challenges posed by HIV. Nine regional, national and institutional training courses for 44 Member States in the African, South-East Asia and Eastern Mediterranean Regions and the Region of the Americas on building country capacity to manage severe malnutrition were held during 2004 and 2005. As a result, there is now a network of 81 trained facilitators to carry on the work at country level; a total of 118 practitioners also received training.

Global, regional and country nutrition surveillance strengthened through development and operation of WHO's nutrition databases and associated nutrition surveillance activities

Indicator	Baseline	Target	Achievement
Number of countries that have nationally representative surveillance data on major forms of malnutrition, and the extent of the national and regional coverage of global nutrition data banks	50 countries	100 countries	180 countries for child anthropometry (95% of under-fives) 97 countries for body mass index (85% adult population, overweight/obesity) 130 countries for anemia 161 countries for food and nutrition policies 168 countries for exclusive breastfeeding and duration of breastfeeding

During the biennium, maintenance and enhancement of the databases continued. An important dimension of the work has been the compilation of an integrated nutrition database to generate country nutrition profiles.

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

Indicator	Baseline	Target	Achievement
Number and proportion (regional and global) of targeted countries receiving technical support that succeed in strengthening their national nutrition plans, policies and programmes	40 countries	30 countries	34 countries (113%)

Four training courses were held to strengthen national capacity in devising and implementing effective intersectoral food and nutrition plans and policies to address emerging and re-emerging nutrition-related health issues, in particular the growing double-burden arising from them. WHO provided capacity-building support to 26 countries in the African, South-East Asia and Western Pacific regions. In addition, nutrition action plans were prepared or adopted in 44 Member States in the European Region. In the African Region, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Democratic Republic of the Congo, Ghana, Guinea, Namibia, Niger, Nigeria, South Africa and Togo reviewed their national nutrition strategies and programmes following two regional consultations. Seven Member States in the South-East Asia Region, Bangladesh, Bhutan, India, Indonesia,

Myanmar, Nepal and Sri Lanka, and five in the Western Pacific Region, Cook Islands, Fiji, Samoa, Tuvalu and Vanuatu, are revising their national nutrition plans and policies. In January 2005, a review of the achievements and challenges of these capacity-building initiatives was conducted with all concerned partner agencies, including FAO and UNICEF, to determine the direction of future work. It is estimated that one-third of the countries that received training have succeeded in strengthening their nutrition plans and programmes.

Nutritional norms, including references, requirements, guidelines, training manuals and criteria for assessing, preventing, managing and reducing the major global forms of malnutrition (under- and over-nutrition) and promoting healthy nutrition, produced and disseminated to countries and the international community

Indicator	Baseline	Target	Achievement
Number and nature of nutrition standards, guidelines and training manuals produced and disseminated to countries and the international community	0	5	5 (100%)

Five publications were produced on the following: severe malnutrition,[1] vitamin and mineral requirements in human nutrition, [2] infant feeding in emergencies,[3] guiding principles for feeding infants and young children during emergencies[4] and feeding the non-breastfed child.[5]

Technical support provided to countries for meeting the needs of nutritionally vulnerable, food-insecure groups, particularly through collaboration with the World Food Programme and the food-assisted emergency and development projects of other international agencies

Indicator	Baseline	Target	Achievement
Adequacy of WHO's response to requests for technical support – from the World Food Programme, other international organizations and high-priority countries – for nutritional emergency and food-assisted development work	Limited capacity to respond to requests for technical support	Improve WHO response to major emergencies	Agreement reached with United Nations partners within the Inter-Agency Standing Committee Nutrition cluster on the roles and responsibilities of WHO

WHO has been present at all major emergencies during 2004-2005 principally, the Indian Ocean earthquakes and tsunamis, the flooding in Djibouti and the famine in Niger, through its participation in assessment missions that focused on both nutrition and health action in crises. It has also participated in drawing up a workplan for the Nutrition cluster of the Inter-Agency Standing Committee in which the respective roles and responsibilities of the United Nations agencies in responding to emergencies were agreed. Following the restructuring of the nutrition in emergencies area, the recruitment of new staff is almost complete.

Success factors and impediments

Success factors

- Networking with regional offices to consolidate the nutrition area of work strengthened through joint planning sessions.
- A more focused approach and better internal linkages between programme areas as a result of the restructuring process.

[1] *Severe malnutrition: report of a consultation to review current literature, 6-7 September 2004*. Geneva, World Health Organization, 2005.

[2] *Vitamin and mineral requirements in human nutrition.* Geneva, World Health Organization, 2005.

[3] *Infant feeding in emergencies: Module 1 – for emergency relief staff.* WHO, UNICEF, LINKAGES, IBFAN, ENN et al, 2001; and *Module 2 – for health and nutrition workers in emergency situations.* ENN, IBFAN, Terre des hommes, UNICEF, UNHCR, WHO and WFP, 2004.

[4] *Guiding principles for feeding infants and young children during emergencies.* Geneva, World Health Organization, 2004.

[5] *Feeding the non-breast child 6-24 months of age: Geneva, 8-10 March 2004: meeting report.* Geneva, World Health Organization, 2004.

Impediments

- Despite the success of fundraising overall, the earmarking of a significant proportion of the funds raised by the department led to a reduction in the resources available for some activities.
- Weak operational capacity in some regional offices given the magnitude of the challenges faced, for example, in the Regional Office for Africa.

Lessons learnt in 2004-2005 and how they will be applied in 2006-2007

- Joint planning will continue in 2006-2007 to further strengthen networking with regional offices.
- The budget structure hinders achievement of all Organization-wide expected results. More unspecified funds for key underfunded areas will need to be found in 2006-2007. Activities that do not have sustainable long-term funding will not be initiated.

Approved budget and actual expenditure

		Approved budget	Actual expenditure		
			Regular budget	Other sources	All funds
Total 2004-2005 (US$ thousand)		20 526	8 134	9 272	17 407
Percentage	countries	27	23	7	14
	regions	24	39	21	29
	global	49	38	72	57

HEALTH AND ENVIRONMENT

WHO objective(s)

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

Indicator(s) and achievement

- *Enhanced incorporation of environmental health aspects into international and national policy declarations and development programmes.* At global, regional and national levels, efforts to enhance incorporation of environmental health aspects into policy declarations and development programmes were successful. Examples included the twelfth and thirteenth sessions of the Commission on Sustainable Development; the Fourth Summit of the Americas; the Fourth Ministerial Conference on Environment and Health (Budapest, 23-25 June 2004); the entry into force of the Stockholm Convention on Persistent Organic Pollutants (POPs) and of the Rotterdam Convention on the Prior Informed Consent Procedure for Certain Hazardous Chemicals and Pesticides in International Trade, in 2004; of the Protocol on Water and Health, in 2005; and the High Level Meeting of ASEAN and East Asian Countries on Health and the Environment in December 2005.
- *Increased use of WHO policy guidance by sectors other than health with responsibility for environmental management and socioeconomic development.* Use of WHO policy guidance by both health and non-health sectors was enhanced, especially in those sectors with responsibility for environmental management and socioeconomic development. Tracking of application of WHO guidelines by Member States was initiated in selected areas and shows significant use and rapid application.

Main achievements

- There was a shift in emphasis towards country-level action at all levels of the Organization. In the African Region, for example, activity on occupational health was analysed and the outcome adopted by the Regional Committee, leading to increased cooperation with ILO and also to associated country cooperation. Support provided by headquarters for networking and tool development assisted this, and similar initiatives in other regions.
- Increased attention was given to effective dissemination and specifically to increased use of electronic media. In the Region of the Americas, the network on safety and health at work reaches 80% of occupational health and safety experts in targeted institutions and countries, with more than 1600 subscribers in 38 countries. Web sites concerning the Department of protection of the human environment are among the most frequently accessed of all web sites at headquarters and free distribution of the Organization's CD-ROMs on this subject can exceed 100 000 per annum.
- Application of settings-based approaches makes it possible to have an impact on multiple hazards; during the biennium special attention was given to children and to the health-care settings, with notable action in all regions and at headquarters.
- Public health and environment issues attracted increasing attention in interministerial and intergovernmental processes, as outlined above.
- The biennium was marked by a number of disasters that tested systems and resources beyond normal limits. In particular, the response to the Indian Ocean earthquakes and tsunamis which was coordinated by the Regional Office for South-East Asia, mobilized resources from headquarters and a number of regions. A major area of action was the re-establishment of basic services such as water and sanitation to prevent disease outbreaks and provision of support for reconstruction efforts. The outcome also led to increasing overall attention to emergency preparedness and response.
- The third edition of the *Guidelines for drinking-water quality*[1] is the second-most frequently downloaded WHO publication. On the basis of this document, a major area of activity by regions was dissemination and capacity building to support Member States in tackling water-related hazards.

[1] *Guidelines for drinking-water quality.* Vol 1: 3rd ed. Available at http://www.who.int/water_sanitation_health/dwq/gdwq3/en.

Achievement of Organization-wide expected results

Adequate support provided to the health sector for building capacity in targeted institutions of high-priority countries in order to manage environment and health information and implement action plans

Indicator	Baseline	Target	Achievement
Proportion of institutions in targeted countries in each region receiving support to exchange national or local information and to implement health and environment action plans	Not established	Not established	Targeted institutions in approximately 75% of Member States received support

This expected result was established in order to focus activity on the benefits of increasing support to targeted institutions. Although targeted institutions in approximately 75% of Member States received support, in many instances a number of different institutions dealing with different aspects of environment and health were supported, and this statistic therefore underrepresents overall activity. The biennium marked a significant shift towards country focus, which was reflected in support to targeted institutions in most countries and all regions. In the Western Pacific Region, for example, activities included working with five countries to develop environment and health capacities and convene national forums on environment and health; nine countries were assisted in identifying major and common environment and health issues and in strengthening effective collaboration between the health and environment sectors, and an intercountry workshop on drinking-water quality in Pacific island communities provided new information and led to a framework for action for implementation in all Pacific island countries.

Appropriate technology and logistic support provided for prevention, preparedness and response to chemical incidents and poisonings, radiation accidents and other technological or environmental emergencies

Indicator	Baseline	Target	Achievement
Efficient response from WHO offices to requests for technical guidance and cooperation on preparedness and response to natural or manmade environmental emergencies	Increasing number of environment-related enquiries, and increasing numbers of events and affected persons. Limited internal coordination of associated activities	Improved coordination, more timely and appropriate responses	Significantly increased cooperation among regional offices, within headquarters and between headquarters and regional offices directed towards prevention, preparedness, response and reconstruction

Significantly increased cooperation among regional offices, within headquarters and between headquarters and regional offices occurred during the biennium. This was directed towards prevention, preparedness, response and reconstruction. At the same time, the set of resource materials to support action was increased and subjected to significant field evaluation. Procedures are being developed and tested for further enhancement of response and greater emphasis on preparedness. Two major environment-related emergencies (the Indian Ocean earthquakes and tsunamis and the south Asia earthquake) occurred during the biennium. In both cases, country, multiregional and headquarters resources were mobilized. The experience gained from these and other events indicates that a faster response was achieved, supported by an increase in associated supporting resources (networking, tools and guidance). In the Eastern Mediterranean Region alone, support to develop increased country preparedness was provided to eight Member States; dedicated response capacity within WHO was also consolidated; three operations were mounted in response to chemicals emergencies, and 285 requests for technical guidance were responded to.

Community participation and other initiatives launched for addressing environmental health concerns of vulnerable population groups, particularly children, workers and the urban poor

Indicator	Baseline	Target	Achievement
Efficient response from WHO offices to the needs of high-priority target groups including communication and education activities	Limited and ad hoc activity targeting vulnerable groups as regards environment and health	Improvement sought in both identification of and response to Organization-wide priority groups, and in overall delivery activity	Significantly increased activity seen across all levels of the Organization, with attention given especially to children and to health care. Efficiency enhanced through systematic development of networking within initiatives and increased use of electronic media

Targeting action on high-priority groups was identified as a means of significantly improving the overall impact of actions across the Organization. Significantly increased Organization-wide activity included increased numbers of, and levels of participation in, partnerships and networks and associated tools and promotional actions. Special efforts were directed towards children and health care (safe physical environment and adequacy of health-care workers). In the European Region high-priority groups were targeted, in part, through a region-wide "training of trainers" network, with health-care providers as the primary target group in 18 countries and the aim of raising awareness of children's health and environment. Other vulnerable population groups targeted included the rural and urban poor and workers and settlements with no access to clean fuels, water or sanitation.

Science-based health impact assessments undertaken of socioeconomic and technological developments, and of global change in climate, biodiversity, water resources, and disease-vector habitats and other ecosystems

Indicator	Baseline	Target	Achievement
Availability of comprehensive assessment methodology; extent to which global health and environmental issues are addressed and the related environmental burden of disease quantified	39 assessments developed or updated in previous 36 months	47	58 assessments and assessment methodology tools developed or updated in previous 36 months

Health impact assessment activity underpins much health and environment policy advice and decision-making. The indicator formulation captures availability of methodology and specific assessments undertaken by headquarters and regional offices. However, it fails to reflect efforts, especially at regional and country levels, to support development of country capacities. The European, Eastern Mediterranean and Western Pacific Regions all undertook substantial activities in a number of countries and further outreach activity was undertaken in all regions.

Occupational and environmental health risks assessed and communicated through national and international partnerships, alliances and networks of centres of excellence

Indicator	Baseline	Target	Achievement
Increase in number of intergovernmental bodies, nongovernmental organizations, professional associations and scientific institutions collaborating with WHO on health and environment issues	14 substantive interagency networks; plus further multicountry initiatives	18 substantive interagency networks; plus further multicountry initiatives	27 substantive interagency and multicountry initiatives

Development of partnerships for increased impact featured in policy recommendations from intergovernmental forums in the period and is reflected in activity in relation to this expected result, especially at regional level. Activity on partnerships focused on those likely to provide significant added value. In the Region of the Americas, the hemispheric strategic alliance of four sectors (health, labour, environment and education) provided impetus to the implementation of the mandate of the Fourth Summit of the Americas regarding occupational health and safety. Other important new partnerships developed during the biennium addressed children's health and environment, workplace health, drinking-water, climate change, health-environment linkages and indoor air pollution.

Evidence-based normative guidelines in key environmental health areas (air and water quality, workplace hazards, radiation protection) drawn up for the purpose of framing policy and setting national and international standards

Indicator	Baseline	Target	Achievement
Number of national and international legal and regulatory instruments making use of WHO environmental health criteria and guidelines	13 updated guidelines	16 updated guidelines, with evidence to confirm significant use in national and international regulatory instruments	19 updated guidelines. Available qualitative evidence indicates extensive application

The target of 16 updated normative guidelines was slightly exceeded, with significant progress on chemical, radiological and water-related guidelines. Regional activity during the period principally targeted the recently published third edition of the *Guidelines for drinking-water quality*, with significant support to country requests for assistance in most regions, in particular, in the South-East Asia, European, Eastern Mediterranean and Western Pacific Regions.

Good-practice tools and guidelines produced on cost-effective interventions for reduction of health risk from exposure to harmful environmental agents, workplace hazards, new technological developments, and global change in climate

Indicator	Baseline	Target	Achievement
Access of national and local health authorities and environmental agencies to WHO guidelines in both electronic and printed format for the planning and implementation of health and environment protection	8 up-to-date tools and assessments.	16 up-to-date tools and assessments, with evidence on access	24 up-to-date tools and assessments. Review of data on access through conventional and electronic means confirms wide and increasing access

Provision of up-to-date tools and guidelines on cost-effective interventions significantly exceeded the target. This was largely due to accelerating action in areas of high demand from Member States, such as estimating costs and impacts of interventions and estimating burden of disease. At headquarters and regional levels significant effort was put into translation and increasing overall dissemination through conventional and electronic means. The 16 new guidelines developed during the biennium concern especially overall burden-of-disease estimation, and cost-effectiveness/cost-benefit analysis; occupational health; poisoning prevention; hazard-specific guidance (e.g. noise, radon, fluoride, ultraviolet radiation) and intervention-based assessments (e.g. impact of household water management).

Success factors and impediments

Success factors

- The role of formal policy mandates derived from intergovernmental and interministerial events, conventions and protocols.
- Exploitation of electronic means to enhance overall information dissemination.
- Credibility of WHO among practitioners and Member States in the subject matter of the area of work, based on its established reputation and ongoing delivery of scientific evidence on issues of practical concern.
- Improved interagency cooperation in some areas (e.g. water through UN-Water, emergency response).
- Cooperative action with partners.

Impediments

- Financial resource constraints.
- Weak role of health institutions in health and environment in some Member States.
- Inadequate interagency cooperation in some areas.
- Limited health and environment staff resources at all levels aggravated by exceptional demands on staff (e.g. tsunami-response).

Lessons learnt in 2004-2005 and how they will be applied in 2006-2007

- With increasing country-level focus, the value of coordinated action across all levels of the Organization (country offices, regional offices and headquarters) is increasingly evident. One example involved AusAID support to the South-East Asia and Western Pacific Regions, selected countries and headquarters. Such opportunities should be further explored to increase overall resource availability and capacity for coordinated action, and to enhance action in priority areas.
- Experience has highlighted the critical role of effective action at all levels of the Organization and especially country offices in ensuring overall, system-wide impact. Action will be taken to develop a coordinated global strategy for public health and environment and to ensure ongoing responsiveness to country planning processes.
- The importance of multi-language availability of resources is increasingly evident and reflected in substantive translation activities in regional offices and at headquarters. This will be more systematically pursued, inter alia through use of electronic media.
- The benefit of multisectoral action and of collaborative initiatives on overall health impact has been highlighted. This will be further enhanced in 2006-2007 through networking and partnership-based actions and through use of supportive tools, for example, to assess costs and impacts of interventions.
- In order to respond adequately to the benefits of multisectoral action for health, it will be necessary to enhance health-sector inputs to intersectoral processes, both internationally and in Member States where institutional arrangements might further assist the process. This includes provision of tools to facilitate coordination and engagement with sectors that manage environmental determinants of health. Efforts will therefore be made to "reposition" health and environment to assist health-supporting actions by sectors other than health.

Approved budget and actual expenditure

		Approved budget	Actual expenditure		
			Regular budget	Other sources	All funds
Total 2004-2005 (US$ thousand)		86 946	35 133	42 492	77 625
Percentage	countries	35	37	5	20
	regions	32	34	37	35
	global	33	29	58	45

FOOD SAFETY

WHO objective(s)

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

Indicator(s) and achievement

Number of countries presenting or providing data on foodborne diseases and food hazards in order to launch and evaluate risk-based intervention strategies. Ninety-four countries provided data on foodborne diseases surveillance.

Main achievements

- The Codex Trust Fund supported the participation of 393 experts from 104 developing countries in 30 Codex meetings and a related training course.
- Pilot projects on a draft training manual based on the "five keys to safer food" were carried out in two or three countries in each WHO region. The original poster has been translated into more than 40 languages.
- The International Food Safety Authorities Network and its emergency component were launched in 2004 to provide regulators with up-to-date information on food safety and risk management. By December 2005, 145 countries had joined the network.
- Guidelines were prepared on reducing the risk of avian influenza virus in wet/live animal markets and setting up healthy food markets in the South-East Asia and Western Pacific regions. A joint FAO/OIE/WHO consultation on avian influenza and human health was held in Kuala Lumpur in July 2005 to discuss risk reduction measures in producing, marketing and living with animals, and an associated advocacy document was produced. Guidance for Member States on improving biosecurity in the food chain supply was posted on the WHO web site and disseminated to relevant countries.
- The issue of a report on modern food, biotechnology, human health and development,[1] was followed by the fifth session of the Codex adhoc Intergovernmental Task Force on Foods Derived from Biotechnology, held in Chiba, Japan in September 2005.
- The Global Environment Monitoring System – Food Contamination Monitoring and Assessment Programme was strengthened and now includes information from about 42 countries.
- Risk assessments were performed and results published concerning *Enterobacter sakazakii* and other microorganisms in powdered infant formula[2] and Listeria monocytogenes in ready-to-eat foods.[3]

Illustration of selected achievements

The first pan-African conference on food safety in Africa, convened jointly by WHO and FAO, was attended by more than 185 participants from 45 African Member States and observers. In addition to other recommendations, delegates unanimously adopted a resolution recommending a nine-point five-year strategic plan for food safety in Africa for adoption by food and health agencies and the African Union.

[1] *Modern food, biotechnology, human health and development: an evidence-based study*. Geneva, World Health Organization, 2005.

[2] *Enterobacter sakazakii and other microorganisms in powdered infant formula: meeting report*. Geneva, World Health Organization, 2004.

[3] *Risk assessment of Listeria monocytogenes in ready-to-eat foods: technical report*. Geneva, World Health Organization, 2004.

Achievement of Organization-wide expected results

Foodborne disease surveillance and food hazard monitoring and response programmes strengthened

Indicator	Baseline	Target	Achievement
Number of countries reporting results from a system for monitoring hazards (microbiological and chemical)	Microbiology: 4 countries based on global *Salmonella* surveillance data in early 2004	14 countries	11 countries
	Chemical: 42 countries listed in Global Environment Monitoring System – Food Contamination Monitoring and Assessment Programme database	47 countries	35 countries
Number of countries with surveillance data on one or more foodborne diseases	22 countries providing data to global *Salmonella* surveillance survey in early 2004	27 countries	66 countries

The global *Salmonella* surveillance survey enhanced capacity to assess risk and manage *Salmonella* and other foodborne pathogens such as *Campylobacter*. Eleven countries reported data on microbiological monitoring. Training in epidemiology and laboratory standard techniques at regional and country levels has been central to capacity building and, as a result, 66 countries reported surveillance data. With regard to the Global Environment Monitoring System – Food Contamination Monitoring and Assessment Programme, European data on exposure and intake are available on the summary information on global health trends databases. Thirty-five countries reported results from their chemical monitoring. Other achievements include the organization of the third international workshop on total diet studies held in Paris in May 2004, and the launch of the fourth global survey of persistent organic pollutants in human milk in collaboration with WHO/UNEP.

Strengthened international risk assessment and scientific advice, and national capacity to assess risk

Indicator	Baseline	Target	Achievement
Number of risk assessments finalized by WHO and FAO (microbiological and chemical)	Microbiology: 3	Microbiology: 3 more	Microbiology: 2 more
	Chemical: pesticides 26, food additives 27, contaminants 5 and veterinary drugs 7	Chemical: same productivity	Chemical: 118 made up as follows: pesticides 52, food additives 54, contaminants 5 and veterinary drugs 7
Number of countries with documented risk assessment activities (microbiological and chemical)	Not applicable	30% increase	43

In the European Region, 25 European Union countries adopted methods to manage risk associated with new technologies such as genetically modified foods. In the Eastern Mediterranean Region, four out of 22 Member States adopted assessment and evaluation methodologies. In the African Region, regional guides on microbiological monitoring of food and the development and drafting of food law are being printed and will be disseminated.

Tools for assessment and management of the risks and benefits associated with products of new technologies in food developed and disseminated

Indicator	Baseline	Target	Achievement
Number of tools developed and disseminated by WHO	4 FAO/WHO expert consultation reports on risk assessment and 3 Codex guidelines on performing risk analysis	2 additional consultations on risk assessment and 1 report on broader evaluation of genetically modified food	1

A report on broader evaluation of genetically modified food was published.

Health considerations in multisectoral food-safety activities at national and international levels strengthened

Indicator	Baseline	Target	Achievement
Number of countries participating actively in international standard setting (Codex Alimentarius Commission)	Participation of 89 developing countries in Codex Alimentarius Commission meetings	25% increase in number of countries participating	122 (37% increase)
Number of countries assisted by WHO to establish or amend food safety policies, legislation and enforcement strategies	Not applicable	20 countries	43

A total of 104 countries were supported by the Codex Trust Fund to attend various Codex expert meetings. A regional guide on food law was prepared in the Eastern Mediterranean Region and several Member States drafted national action plans, food safety policies and legislation, and harmonized their food safety systems. In the Region of the Americas, the PAHO/WHO Plan of Action for Technical Cooperation in Food Safety 2006-2007 was adopted by the Fourteenth Inter-American Meeting, at the Ministerial Level, on Health and Agriculture in April 2005,[1] and was subsequently adopted at the Forty-sixth session of the Directing Council of PAHO.[2] During the biennium, the second FAO/WHO Global Forum of Food Safety Regulators was convened in Bangkok, in October 2004 and four joint regional conferences on food safety were held in Costa Rica, Jordan, Malaysia and Zimbabwe. Action was also taken to support WHO's response to avian influenza in the South-East Asia and Western Pacific regions. The Global Forum of Food Safety Regulators and regional conferences on food safety increased awareness and political will, particularly in the African and Eastern Mediterranean regions and the Region of the Americas. In the European Region, guidelines on the establishment of intersectoral food safety strategies were developed during the biennium and adapted to specific national needs.

Capacities in the areas of risk communication and food-safety education strengthened

Indicator	Baseline	Target	Achievement
Number of countries that have used and evaluated food safety material based upon the WHO "five keys to safer food"	Not applicable	10 additional countries	55

In response to strong country interest, the International Food Safety Authorities Network was extended during the biennium. Using the "five keys to safer food", as a model, guidelines on simple food handling were developed and translated into local languages for dissemination in the South-East Asia and Western Pacific Regions. Nine Member States participated in pilot studies on the "five keys" manual, 55 Member States are using the manual and related learning/teaching aids and the original poster has been translated into more than 40 languages. In the Region of the Americas, guidelines on strengthening national food safety programmes, a manual based on the "five keys to safer food" and technical bulletins issued by the International Food Safety Authorities Network on emerging food safety issues such as acrylamyde and avian influenza, have been widely disseminated. In the Eastern Mediterranean Region, "five keys to safer food" materials were distributed to schools and

[1] Resolution RIMSA.R7.

[2] Resolution CD42.R.3.

households as a health education tool and to reinforce community empowerment in villages in close collaboration with community-based initiatives and women's health development units.

Success factors and impediments

Success factors

- More frequent exposure of food safety and food animal production issues in international media as a result of the avian influenza crisis.
- Increasing political support for farm-to-fork policies and integrated food safety authorities in some Member States, particularly developed countries.

Impediments

- Insufficient allocation of funds for food safety in several regions, and its negative effect on the identification and mobilization of adequate extrabudgetary resources, coupled with late and inadequate funding to carry out risk assessment and Codex work.
- Increased workload in some countries due to disease outbreaks and emergency events.

Lessons learnt in 2004-2005 and how they will be applied in 2006-2007

- Cooperation and collaboration between all stakeholders, especially health, food and environment agencies, are required to avoid duplication of efforts. Therefore, efforts to work with FAO, UNEP and OIE on relevant food production and environmental issues will be pursued in 2006-2007.
- Successful resource mobilization during the preparation of projects such as healthy food markets and the application of the WHO "five keys to safer food" will be scaled up in 2006-2007.
- Capacity-building efforts should be aimed at promoting strategic risk-based planning in countries instead of funding laboratory equipment and training.

Approved budget and actual expenditure

		Approved budget	Actual expenditure		
			Regular budget	Other sources	All funds
Total 2004-2005 (US$ thousand)		22 453	8 565	5 494	14 059
Percentage	countries	43	29	3	19
	regions	26	28	12	22
	global	31	43	85	59

EMERGENCY PREPAREDNESS AND RESPONSE

WHO objective(s)

To ensure that Member States and the international community are better equipped to prevent disasters and mitigate their health consequences, balancing relief against sustainable health development through appropriate coordination mechanisms and emergency response.

Indicator(s) and achievement

Evidence of national disaster-reduction policies and plans that address preparedness and relief taking into account longer-term development perspectives. Seventy-eight Member States included a component for emergency preparedness and response in country cooperation strategy documents. The Hyogo Framework for Action 2005-2015 was adopted by 164 countries at the World Conference on Disaster Reduction held in Kobe, Hyogo, Japan, from 18 to 22 January 2005. The Framework sets out strategic disaster-reduction goals and priorities and key activities to achieve them. In a resolution adopted at that conference, all parties agreed to develop indicators and targets to monitor achievement of the strategic goals set out in the Framework.

Main achievements

- WHO was able to respond promptly to the earthquakes and tsunamis of 26 December 2004 thanks to an extraordinary effort at all levels of the Organization, with regional and headquarters staff joining colleagues in the South-East Asia Region to plan and implement WHO's response. More than 200 staff were deployed to the affected countries in the first few weeks following the disaster.
- WHO was nominated lead agency of the Inter-Agency Standing Committee's Health Cluster in 2005 so as to bring strong technical leadership to coordination of the work of the cluster. The Organization now has a strong platform from which to advocate the central importance of health in emergencies.
- WHO successfully implemented the Health Cluster approach after the South Asia earthquake of 8 October 2005. The coordination mechanism was activated at global and national levels, in close collaboration with other United Nations and humanitarian partners.
- There was an increase in extrabudgetary donations for WHO's emergency response and recovery work, reflecting donors' interest in WHO's evolving role and its attempts to become more operational in emergencies.
- WHO expanded its field presence for this area of work using extrabudgetary funds donated for the Three-year Programme to enhance WHO's performance for health action in crises, which aims to build the institutional capacity in emergency preparedness, response and recovery. Around 60 staff were been recruited and assigned to key field locations.
- WHO is increasingly recognized as the authoritative agency in the management of health information for emergencies. State-of-the-art publications such as the manuals on analysing disrupted health sectors and on management of dead bodies in disaster situations were posted on its web site. Its health needs assessments and mortality surveys have helped to highlight emerging crises and formulate appropriate response strategies. Its initiative to develop standards and benchmarks to track health is a priority for the Health Cluster.
- Many countries in the Region of the Americas with solid emergency preparedness programmes were able to respond to natural disasters without recourse to external assistance.
- WHO opened 16 field offices to implement its emergency response activities and improve monitoring of the evolving health situation in various incipient or continuing crises.
- Following the South Asia earthquake, WHO worked closely with national authorities in Pakistan to assess needs, establish health priorities, restore primary health-care services, coordinate health actions and set up an early warning disease alert and response system.
- WHO's recovery work in complex emergencies resulted in increased visibility and recognition of its work in crises. In addition, its prompt and effective response to other emergencies, including the food crisis in Niger in autumn 2005, the numerous major hurricanes in the Americas and the evolving crisis in the Democratic Republic of the Congo was widely recognized by its donor and humanitarian partners.

Illustration of selected achievements

- The importance of health information as a reliable indicator of crises was reinforced by WHO's crude mortality surveys in Darfur, Sudan, which helped bring the crisis to international attention, and its crude and under-five mortality surveys in northern Uganda, which showed that mortality rates were well above emergency thresholds. Overall, WHO's work in emergencies gained increased recognition and visibility thanks to its efforts in post-war Iraq, where it is supporting the rehabilitation of health systems; in Darfur, where it is supporting the provision of emergency services to the internally displaced population; in drought- and locust-affected Niger, where it produces regular updates on patterns and trends of diseases and malnutrition; in Pakistan, where it has effectively coordinated the Health Cluster response following the earthquake of October 2005; and in many other countries.

Achievement of Organization-wide expected results

Policy and advocacy positions that promote health as the leading concern in emergencies

Indicator	Baseline	Target	Achievement
Evidence of countries and agencies adopting policies which recognize health as a key element to address in emergency situations (e.g. number of country cooperation strategy documents including a component for emergency preparedness and response)	18	78	See details in text

The expected result was largely achieved. With the creation of the Inter-Agency Standing Committee's Health Cluster, United Nations and other humanitarian organizations explicitly recognized the central importance of health in emergencies. Within the Standing Committee, WHO has been instrumental in promoting the health aspects of crises and ensuring that health is recognized as a key component of disaster preparedness and response. WHO was nominated lead agency of the Cluster in 2005. In addition, 17 Member States in the African Region, all in the Region of the Americas, 12 in the European Region and three in the Western Pacific Region have included a component for emergency preparedness and response in country cooperation strategy documents. In November 2005, the 11 Member States of the South-East Asia Region, in collaboration with WHO, developed benchmarks and targets for monitoring and strengthening countries' emergency preparedness and response plans. Six Member States in the Eastern Mediterranean Region now recognize that health is a key component in emergency response strategies.

Reliable, independent and timely public health information produced and promoted for decision making and resource allocation at national and international levels for emergency preparedness and response

Indicator	Baseline	Target	Achievement
Number of tools developed and systems, including health information for emergency response preparedness and vulnerability reduction in place in Member States	Not established	Not established	Some 30 new or updated covering various aspects of health information management for emergency preparedness and response were produced

The biennium saw a substantial growth in WHO's role and authority in managing health information in crises. Around 30 new or updated tools covering various aspects of health information management for emergency preparedness and response were produced, including templates for rapid health needs assessments. WHO's manual entitled *Analysing disrupted health sectors*, published late in 2005, covers the main areas relevant to the study of disrupted health sectors, offering practical advice, experiences from the field, tools, references and suggestions for further study. The importance of health information as a reliable indicator of crises was reinforced by WHO's crude mortality surveys in Darfur, Sudan, and northern Uganda. This area yields tangible products and a strategic service line. Partners increasingly expect WHO to take the lead in needs assessments and in tracking performance and outcomes (mortality and survival) in different contexts.

Effective support provided to the health sector of Member States to institutionalize local capacity to reduce vulnerability of people and health facilities as well as prepare for and act in emergencies

Indicator	Baseline	Target	Achievement
Number of countries including disaster mitigation in technical cooperation policies	Not established	Not established	Not established
Number of trained Health Action in Crises/Emergency and Humanitarian Action focal points present at regional office and country office levels	73	300	400

The Three-year Programme to enhance WHO's performance for health action in crises has been instrumental in building capacity to support Member States' efforts to prepare for and respond to crises at field level. The Programme centres on WHO's four key functions in emergencies (assessing health priorities; coordinating health actions; identifying and filling gaps; and supporting local capacity and systems strengthening). At the beginning of the project around 60 staff were recruited, briefed extensively on the goals of the Programme and assigned to countries of strategic interest, mainly in the African Region. As a result of WHO's strengthened field presence, emergency work is being increasingly integrated into country plans and the quality of its contribution to the Consolidated Appeal Process has improved substantially. Around 400 WHO staff and partners were trained in the course of the biennium in a total of 11 events held in Geneva, and in Congo, Democratic Republic of the Congo, Egypt, Ethiopia, Kenya and Uzbekistan. Training courses include an induction course, a workshop on managing health information in crises, a course on project management, and a training course for trainers.

Alliances, involving health systems, United Nations agencies, nongovernmental organizations and other entities to reduce vulnerability, provide effective health assistance in ways that are transparent and accountable

Indicator	Baseline	Target	Achievement
Rate of funding coverage of health components in consolidated appeals	30%	50%	69%
Number of joint projects and memoranda of understanding with partners for disaster reduction at country level	Not established	Not established	Several projects (see below)

WHO and the International Federation of Red Cross and Red Crescent Societies marked their strengthened collaboration with the signature of a joint letter of understanding in May 2005. In the African Region, 13 joint projects were initiated at country level. In the Eastern Mediterranean Region, WHO implemented projects with major partners including UNICEF, UNDP and the International Federation of Red Cross and Red Crescent Societies in The Islamic Republic of Iran, Jordan, Somalia, and Sudan. The Regional Office for Europe continued to work closely with UNDP, UNICEF, UNHCR and other partners on contingency planning and other activities. The Regional Office for the Americas is developing a joint emergency preparedness workplan with the International Federation of Red Cross and Red Crescent Societies and UNICEF. WHO's Regional Offices for South-East Asia and the Western Pacific concluded a joint memorandum of understanding with the Asian Disaster Preparedness Center for emergency preparedness training, and conducted three interregional and at least six national training courses for a total of almost 300 people. The Regional Office for the Western Pacific continued to work closely with the European Commission's humanitarian aid department (ECHO), the Japan International Cooperation Agency, the ASEAN Committee on Disaster Management and others. As regards funding through consolidated appeals, the target of 50% was surpassed, but the funds raised were unevenly distributed, with some appeals (notably for the tsunami disaster) over-funded while others were not funded at all.

Greater leadership of WHO in coordination of international health disaster reduction and response efforts

Indicator	Baseline	Target	Achievement
Number of regional and country offices meeting the minimum requirement for operations	Not established	Not established	Not established
Number of external evaluations recognizing the relevance of WHO technical assistance in emergency work	1	2	7

Good progress has been made in this area. Two months after the earthquakes and tsunamis of December 2004, WHO organized an externally facilitated internal review to take stock of its operations and identify lessons to be learnt. In November 2005 WHO carried out an internal review of its response operation in Pakistan following the previous month's earthquake. In addition, joint WHO/donor reviews of WHO's emergency field work were carried out in 2004-2005. WHO, together with the United Kingdom Department for International Development, the Swedish International Development Authority and the European Commission's humanitarian aid department (ECHO), reviewed its humanitarian operations in Chad, Democratic Republic of the Congo, Indonesia, Liberia, Sri Lanka and Sudan. The reviews showed that, while in some countries WHO had been able fully to implement its core tasks and functions, in others the effects of its attempts to strengthen its emergency operations were not yet visible. The reviewers also highlighted the crucial importance of surge capacity, standard operating procedures, procedures for delegation of authority, an emergency response fund and a solid logistic and administrative system for the rapid deployment of personnel, supplies and equipment in the event of an emergency. In 2004 WHO and UNHCR developed a joint initiative to evaluate health and nutrition. An internal evaluation of WHO's emergency work in flood-affected Guyana was also conducted. Three pilot evaluations were carried out in 2004, in Nepal, Pakistan and Zambia, on the health and nutrition situation and responses for the refugee populations in those countries. In 2005, health-sector-wide evaluations were carried out in Burundi and Liberia. Recommendations generally included guidance on how to improve consistency between various stakeholder projects, and the transfer of knowledge and responsibilities from nongovernmental organizations to local health authorities. The findings of these evaluations have now been incorporated into the work of both the health and nutrition clusters, and will be used to reformulate health sector strategies and technical guidance.

Availability of authoritative and up-to-date scientific information on best practices and policies for disaster reduction and humanitarian assistance

Indicator	Baseline	Target	Achievement
Number of joint lessons learnt, exercises documented and circulated/promoted	2	4	4
Number of technical publications reflecting WHO's best practices and policies for disaster reduction	Not established	Not established	Several publications, as detailed below

WHO convened a major conference in Phuket, Thailand, in May 2005, focusing on the health lessons learnt from the tsunami disaster of December 2004, both in the immediate aftermath and during the early phase of recovery. A full report of the proceedings was published in the *Prehospital and Disaster Medicine* .[1] WHO is also a member of the Tsunami Evaluation Coalition, a learning and accountability initiative with more than 50 member agencies, the aim of which is to promote a sector-wide approach to tsunami response evaluations in order to optimize sector-wide learning. The first reports are expected in February 2006. Other joint lesson-learning exercises included a workshop organized by WHO, the Ministry of Health of the Islamic Republic of Iran and other partners in the wake of the earthquake in Bam in 2003. Over 5000 Health Library for Disasters CD-ROMs and over 29 000 copies of the manual on management of dead bodies were distributed in various languages. New publications included guidelines on malaria control, nutrition, mental health and HIV/AIDS in emergency settings, on the clinical management of survivors of rape, and many others. Regional publications included an emergency response manual and national pocket emergency tool produced by the Regional Office for the Western Pacific, and a mental health preparedness manual produced by the Regional Office for the Americas.

Success factors and impediments

Success factors

- WHO's improved performance in recent crises has reinforced its credibility as a leader in emergency health management. It has also reaped dividends in the form of donor trust and generous contributions from governments, the private sector and the general public. Donors are increasingly interested in WHO's work in emergencies and its efforts to move to a more operational role.
- Many donors and United Nations and humanitarian organizations now recognize health as a central issue in emergencies. Health ministries increasingly recognize that disaster preparedness and management is a crucial element in health planning.

[1] Plianbangchang S. WHO special report: preface. *Prehospital and Disaster Medicine.* 2005: 20(6). Accessible online at http://pdm.medicine.wisc.edu.

- Through excellent collaboration across the Organization the emergency preparedness and response area of work has catalysed the bringing together of relevant technical expertise to respond comprehensively to the health aspects of emergencies (e.g. mental health, maternal and child health and many other departments).
- The influx of funds from the Three-year Programme to enhance WHO's performance for health action in crises has enabled WHO to build up its presence in countries and strengthen its support to Member States at field level.
- WHO's leadership of the Inter-Agency Standing Committee's Health Cluster has enabled it to assume a highly visible role in disaster management and has given it the means to improve coordination of the health sector's emergency response activities.
- The use of health information to draw attention to crises and WHO's authority in this area are increasingly recognized by its humanitarian health partners.

Impediments

- This area of work has a small regular budget and relies heavily on extrabudgetary contributions. However, donors tend to fund major emergencies rather than smaller, neglected crises that fail to catch the public eye. In addition, most extrabudgetary donations are tightly earmarked for direct disaster relief and do not cover WHO's normative functions, including emergency preparedness and planning. This leads to funding shortfalls and results in an inherent imbalance in its emergency work.
- Member States still have limited emergency preparedness and capacity-building programmes and contingency plans, despite a heightened awareness of the need to plan for major crises.
- Recruiting and retaining qualified and experienced staff for hardship duty stations have proved to be major constraints.
- Outdated administrative procedures have seriously impeded the optimization of response mechanisms. Repeated experience has shown that WHO's normal administrative processes are not sufficiently responsive and flexible to respond to large-scale emergencies.
- The absence of an emergency revolving fund has hampered WHO's prompt response to major emergencies.

Lessons learnt in 2004-2005 and how they will be applied in 2006-2007

- The large number of major disasters in 2004-2005 served to underline the importance of emergency preparedness. Member States are increasingly calling for greater capacity for disaster preparedness and risk reduction. WHO must work to secure stable funding for its emergency preparedness activities (the difficulties in attracting funds for this area have been described above). It will also be essential to secure stable funding once the Three-year Programme comes to an end in April 2007, to ensure that WHO can build on the programme's achievements and sustain its field presence.
- The lack of qualified field personnel available for rapid deployment is often a major constraint. To counter this deficit, WHO plans to launch the Health Emergency Action Response Network. The network seeks to provide a pool of qualified, experienced and trained international health personnel for rapid deployment in crises and disasters. Donors have expressed keen interest in the concept and WHO hopes to raise enough funds to develop it into a fully-fledged, self-sustainable programme.
- In accepting the role of lead agency of the Health Cluster, WHO faces a twofold challenge: it must provide strong leadership and authoritative guidance to its humanitarian partners, and also show that it is itself willing to undertake the necessary internal reform to enable it to respond effectively in crises. WHO must be able to continue to take the lead in coordinating response efforts, conducting health needs assessments, setting standards and tracking health performance and outcomes.
- WHO's strenuous advocacy efforts to demonstrate that it has the knowledge, the capacity and the momentum to improve its performance in crises have reaped dividends in the form of donor trust and generous contributions from governments, the private sector and the general public. It must maintain this trust and confidence by closely monitoring programme results and showing that it can deliver on its promises. Weak administrative and project management capacity continues to be a major constraint. The quality of reporting to donors is often erratic, and many projects continue to be delayed or over- or under-implemented. This is a key area for investment and improvement in 2006-2007.
- WHO must continue to drive forward the process of developing global standard operating procedures for emergencies. This is a crucial component of both WHO's response mechanisms and its own institutional emergency preparedness. An internal working group set up in 2005 made several recommendations for improving WHO's work in crises, including the development of Organization-wide standard operating procedures, the establishment of an emergency fund, pre-positioning of stocks, clear delegations of authority and the need to delineate responsibilities among the three levels of the Organization. The group will continue its work in 2006.

- As repeatedly emphasized in the Humanitarian Response Review commissioned by the United Nations Emergency Relief Coordinator in 2005, close collaboration and alliances between humanitarian partners are crucial if the international community is to improve its collective response in the aftermath of disasters and emergencies. WHO must continue to build strong partnerships in order to ensure better planning and coordination of emergency response across the health sector. WHO's own response capacity depends on its prior investment in preparing its health sector partners.
- Donors have increasingly insisted that extrabudgetary projects be evaluated by an independent team. In so doing, they have helped ensure that evaluations become an integral part of WHO's work. The challenge for the next biennium will be to institutionalize systematic evaluation of WHO's work in crises. Widespread recognition that such evaluations provide opportunities to learn and thus improve performance will be crucial to ensure strong results in the field and will also strengthen WHO's relationship with its key donors.

Approved budget and actual expenditure

		Approved budget	Actual expenditure		
			Regular budget	Other sources	All funds
Total 2004-2005 (US$ thousand)		119 037	8 574	238 800	247 375
Percentage	countries	82	44	75	74
	regions	11	29	10	11
	global	7	27	15	15

ESSENTIAL MEDICINES: ACCESS, QUALITY AND RATIONAL USE

WHO objective(s)

To work with countries to frame, implement and monitor national drug policies; to increase equitable access to essential medicines, particularly for priority health problems; to ensure the quality, safety and efficacy of medicines through effective drug regulation; to improve rational use of medicines by health professionals and consumers.

Indicator(s) and achievement

Percentage of the global population that has access to essential medicines. Based on 2005 estimates, in 18 countries (13 low-income countries and five middle-income countries) less than half the population has regular access to a basic range of essential medicines; in 46 countries (24 low-income countries, 19 middle-income countries and three high-income countries) between 50% and 80% of the population has regular access to essential medicines. According to 2003 estimates, about one third of the world's population had no regular access to essential medicines. As a result, about 27 000 people die unnecessarily every day.

Number of countries that have a national drug policy, either new or updated within the past 10 years. By the end of 2005, 65 countries had either introduced a new or updated an existing official national medicines policy within the previous ten years.

Main achievements

- Several global policies, norms and standards in the medicines field were established following transparent and standardized technical development and global consultation procedures.
- The prequalification programme is now widely recognized. In the period under review, more than 70 additional priority medicinal products for HIV/AIDS, tuberculosis and malaria were assessed and prequalified.
- The standard WHO/Health Action International methodology for medicine-pricing surveys has been used in at least 40 low- and middle-income countries. Most of the results are publicly available. Recommendations and plans for advocacy and policy interventions in countries have been drawn up.
- The WHO network of country medicines experts in Africa has been strengthened and expanded. Technical support has been provided to Member States for the development, implementation and monitoring of national medicines policies. Support has been provided to regional initiatives for strengthening medicines procurement and supply systems, for example in the Eastern Mediterranean Region, and to combat counterfeiting through the establishment of a rapid alert system in the South-East Asia and Western Pacific regions. Collaboration with subregional economic groups in Africa, for example, the South African Development Community, the West African Economic and Monetary Union and the East African Community, has been intensified in the area of medicines regulation and harmonization.
- WHO published key policy documents and guidelines on traditional medicine policy, including for the regulation of herbal medicines.
- Collaboration with United Nations agencies and international organizations increased outreach in terms of technical advice and policy guidance on public-health-oriented development and implementation of intellectual property rules. In addition, WHO worked closely with, among others, UNICEF, UNFPA, UNAIDS, the World Bank and the Global Fund to Fight AIDS, Tuberculosis and Malaria, to promote coherence in their policies on quality, procurement and intellectual property rights related to medicines. This coordination process is managed by WHO.

Illustration of selected achievements

Despite the continued efforts of countries and partners, there has been no significant impact on the tuberculosis burden in the African Region. A review of the incidence of tuberculosis from 1993-2003 shows that among the three regions where tuberculosis incidence continued to rise, the highest rise was in the African Region. The circulation of poor quality medicines is one of the main reasons for the development of antibacterial resistance to commonly used medicines for treating tuberculosis. To ensure access to quality assured medicines, samples of anti-tuberculosis medicines including rifampicin, isoniazid and combination rifampicin/isoniazid were collected from seven countries for quality control purposes. The result revealed deficiencies in active ingredients and dissolution profiles in some samples. Discussions with the national authorities concerned took place and will continue in order to develop appropriate regulatory measures to address the problem of poor quality anti-tuberculosis medicines.

Achievement of Organization-wide expected results

Adequate support provided to countries to frame, implement, and monitor the impact of national medicine policies, including monitoring of and advice on the impact of relevant trade agreements and globalization on access to medicines

Indicator	Baseline	Target	Achievement
Percentage of targeted countries that have plans for implementing national medicine policies, either new or updated within the past five years	49/103 (48%)	Not established	66/103 (68%)
Number of countries with increased capacity to monitor the implication of relevant trade agreements on access to essential medicines	32/105 (30%)	Not established	13 additional countries

The WHO survey package was reviewed and a new tool for measuring access to medicines at household level was developed and used. For the first time these analyses were carried out during the biennium and a report combining the initial results is available. Technical support was provided for the development, implementation and monitoring of national medicines policies in 16 Western Pacific Region countries, 15 central and eastern European countries, 15 Eastern Mediterranean Region countries and 23 African Region countries. National medicine policies usually take several years to develop and the positive results of this effort are likely to be visible during the next biennium. In the Asia/Pacific region, WHO, in collaboration with UNDP and civil society partners, worked with trade, patent and health officials from 18 countries in the region, to build capacity on awareness and understanding of developments in international law regarding public health and intellectual property issues, and provided technical assistance on the implementation of flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) in national patent laws. In Africa, WHO in cooperation with the African Union, UNDP and civil society partners, organized a workshop to provide training for trade, health and patent officials from 34 countries of the African Union, on developing and implementing public-health-sensitive intellectual property laws, consistent with the TRIPS agreement and the Doha Declaration. In conjunction with the training and capacity strengthening activities, WHO published technical and policy guides on aspects related to the implementation of the Doha Declaration and the TRIPS agreement. WHO also provided technical assistance through regional workshops organized by WTO on the TRIPS agreement, to project WHO's perspective on key issues related to the implications of trade agreements and intellectual property rights on access to medicines.

Adequate support provided to countries to promote the safety, efficacy and sound use of traditional medicine and complementary and alternative medicine

Indicator	Baseline	Target	Achievement
Establishment of a global evidence network and monitoring system on safety and efficacy of traditional medicine and complementary and alternative medicine	No such network in existence	Network established by end 2005	"International Regulatory Cooperation for Herbal Medicines" network established in November 2005
Percentage of targeted countries with laws and regulations on herbal medicine	82/127 (65%)	Not established	98/127 (77%)

A global survey on traditional medicine policy and herbal medicines regulations was carried out to identify the status, difficulties and needs of countries in terms of regulating traditional medicines and complementary and alternative medicines, and possible areas for WHO collaboration and support. Information on traditional medicine in countries is limited and research data and appropriate quality assurance mechanisms are still lacking. More than 120 countries have requested WHO support to strengthen information systems regulatory and research issues. The International Regulatory Cooperation of Herbal Medicines network was established in Ottawa in November 2005, and includes regional bodies such as the Western Pacific Regional Forum on Harmonization of Herbal Medicines, the Pan American Network for the Drug Regulatory Harmonization, the European Herbal Medicines Committee, the ASEAN Product Working Group on Traditional Medicines and Health Supplements and the Latin American Parliament. The network will help resolve problems related to the regulation and safe use of herbal medicines and will foster dialogue on the regulation and safe use of herbal medicines among its members. WHO organized an interregional training workshop on good agricultural and collection practices and good manufacturing practices for herbal medicines; 46 participants from 23 countries, including representatives from national drug authorities, research institutions and the pharmaceutical industry, took part. WHO published key policy documents and guidelines on traditional medicines, including two sets of guidelines on good management practice for herbal medicinal products and assessing the safety and quality of herbal medicines with reference

to contaminants and residues, a monograph on good agricultural and collection practices of *Artemisia annua* L, Volume 4 of the WHO monographs on selected medicinal plants, monographs on commonly used medicinal plants in the Newly Independent States, two further sets of guidelines on basic training in and safety of chiropractic, and basic training in and safety of phytomedicines.

Guidance provided on financing the supply, and increasing the affordability, of essential medicines in both the public and private sectors

Indicator	Baseline	Target	Achievement
Dissemination of guidelines on public health insurance covering medicines	No guidelines available	Guidelines prepared and disseminated	Work not started due to lack of funding
Number of countries with generic substitution allowed in private pharmacies	99/132 (75%)	Not established	85/132 (64%)

The WHO/Health Action International standard methodology for medicine-pricing surveys has now been used in at least 40 low- and middle-income countries, to record the price and availability of 30 generic and branded products. Affordability is measured by comparing medicine costs with the lowest wage in the public sector. The results of most of the country studies have been analysed and are publicly available. Recommendations and plans for advocacy and policy interventions in countries have been developed. A new tool for monitoring the price of medicines has been developed and tested and is ready for use in countries. A regional strategy for improving access to essential medicines in the Western Pacific Region, 2005-2010, was endorsed at the fifty-fifth session of the Regional Committee for the Western Pacific and will serve as a framework for implementation of countries' access policies.[1] An assessment of the situation of local medicines production in 15 African countries was carried out. The results will be analysed and used for the development of a regional framework for strengthening country capacity. The development of global guidance and expansion of the work to all regions were not possible due to a lack of funding. In the European region, work to support Member States in strengthening medicine reimbursement schemes continued.

Efficient systems for medicine-supply management promoted for both the public and private sectors, in order to ensure continuous availability of medicines and contribute to better access to medicines

Indicator	Baseline	Target	Achievement
Percentage of targeted countries with public-sector procurement based on a national list of essential medicines	84/127 (66%)	Not established	85/127 (66%)
Percentage of targeted countries with at least 75% of public-sector procurement subject to competitive tender	58/70 (83%)	Not established	60/70 (85%)

Many countries in all regions received technical support to strengthen their medicine supply systems, including in the preparation of procurement plans for the Global Fund to Fight AIDS, Tuberculosis and Malaria. A survey in the African Region concluded that many countries needed to update their national essential medicines lists to serve as the basis for public procurement strategies. A large intercountry study on the efficiency of the supply systems of faith-based organizations was finalized. In the East Mediterranean Region, support was given to the member countries of the Gulf Cooperation Council, to improve medicine procurement practices.

[1] Resolution WPR/RC55.R.4.

Global norms, standards and guidelines for the quality, safety and efficacy of medicines strengthened and promoted

Indicator	Baseline	Target	Achievement
Number of international nonproprietary (generic) names assigned	About 200 new names assigned per biennium	200	230
Number of psychotropic and narcotic substances reviewed for classification for international control	About 5 psychotropic and narcotic substances reviewed per biennium	5	0 Expert Committee meeting postponed to 2006

During the biennium, WHO assigned 230 new International Nonproprietary Names following adoption by the Executive Board in January 2005 of a revised procedure.[1] In addition, a new nomenclature system was developed and approved for biotechnology products. In view of the overwhelming demand for new norms and standards, an extra meeting of the Expert Committee on Specifications for Pharmaceutical Preparations was held to finalize and approve a quantity of normative materials, including United Nations interagency guidelines on quality assurance in medicine procurement systems and global quality standards for new essential medicines for HIV/AIDS.

Instruments for effective medicine regulation and quality assurance systems promoted, in order to strengthen national medicine regulatory authorities

Indicator	Baseline	Target	Achievement
Percentage of targeted countries operating a basic medicine regulatory system	90/130 (69%)	Not established	104/130 (80%)
Percentage of targeted countries with basic quality assurance procedures in operation	111/137 (81%)	Not established	71/137 (52%)

In six countries in the Western Pacific and South-East Asia regions, methods to combat counterfeit medicines are being developed and tested. A rapid alert system for combating counterfeit medicines was launched in May 2005 and 28 countries have already joined the initiative. The WHO prequalification programme, which aims to save lives and improve health by ensuring the quality, safety and efficacy of medicines, added a total of 31 new antiretroviral products to the list of prequalified products during 2005, further increasing access to a choice of quality products. Additionally, WHO conducted six training courses for local manufacturers and government officials to help build capacity for producing and assessing medicines according to international quality standards. In the African Region, three quality control laboratories passed their prequalification assessments. A five-year regional strategic plan to strengthen regulatory authorities in Africa was formulated at a conference for medicines regulators in Addis Ababa in October 2005. Within this framework, countries receive direct technical support to assess and strengthen their medicines regulatory authorities and to develop human resource capacity. Collaboration is in progress with subregional economic blocs such as the South African Development Community, and the West African Economic and Monetary Union, and other bodies, including the Pan American Network for the Drug Regulatory Harmonization, to facilitate harmonization of medicines regulations.

Awareness raising and guidance on cost-effective and rational use of medicines promoted, with a view to improving medicines use by health professionals and consumers

Indicator	Baseline	Target	Achievement
Percentage of targeted countries that have a national list of essential medicines updated within the past five years	82/114 (72%)	Not established	68/114 (59%)

[1] Resolution EB115.R4.

Indicator	Baseline	Target	Achievement
Percentage of targeted countries that have clinical guidelines updated within the past five years	47/76 (62%)	Not established	57/76 (75%)
Percentage of targeted countries that have started implementing a public-education campaign on rational medicine use	72/120 (60%)	Not established	12/120 (10%)

The fourteenth Model List of Essential Medicines was drawn up in 2005. The Executive Board discussed the issue of rational use of medicines and improving containment of antimicrobial resistance and drafted a resolution which was subsequently adopted by the Health Assembly.[1] In three pilot projects on containing antimicrobial resistance, new surveillance methods for rural areas were developed to study the impact of changes in antibiotic prescribing in the public and private sectors. These new methods are essential for the monitoring of resistance development and to test the impact of interventions to contain it. Some countries operate programmes to promote the rational use of medicines by prescribers and consumers. However, in general there is a large "policy gap" so that although effective policies and interventions exist, fewer than half the countries surveyed are implementing them. This leads to suboptimal treatment outcomes and a waste of economic resources.

Success factors and impediments

Success factors

- Rigorous and standardized methods for developing global normative materials through expert committees and global consultative processes have guaranteed the full independence, high technical quality and excellent reputation of WHO's medicines-related work. Increasing demand and political support for the prequalification programme have increased the Organization's visibility.
- The medicines programme continues to enjoy the support of dedicated staff, many of whom are widely recognized as global experts in their field. Hence, the department is usually able to obtain technical advice and assistance from leading experts. The continuing support given to medicines experts in country offices has strengthened WHO's role and technical capacity at country level and fostered sustained collaboration with Member States.
- WHO's approach, which brings together health, trade and patent officials, facilitates coherence in policy and decision-making in the interrelated areas of public health, trade and intellectual property rights.

Impediments

- Growing dependence on earmarked funding, even for global normative functions, and the related burden of fund-raising and donor reporting have been detrimental to stable staffing and long-term planning and have increased managerial overheads. In future, specific budget lines for programme management, fund raising and donor reporting will be included in all funding proposals, in order to pay for these essential functions.
- The increase in medicine-related work in all disease areas, including the priority diseases HIV/AIDS, tuberculosis and malaria, has led to an inconsistent approach to medicines across departments and a reduction in cost-effectiveness and technical quality. Specific efforts will be directed towards promoting a coordinated and consistent approach to medicine policies across WHO, with a focus on uniform quality standards and evidence-based clinical guidelines in all clusters.
- Knowledge and awareness of intellectual property rights issues and their implications for public health and access to medicines is still low in many countries and local expertise needs further strengthening.

Lessons learnt in 2004-2005 and how they will be applied in 2006-2007

- The demand for WHO's normative guidance and technical support in medicines outweighs the available human and financial resources. Fund-raising, including at the regional and country level, will need to be stepped up. Therefore, in 2006-2007 political advocacy for the global benefits of WHO's normative work, as well as fund-raising activities, will be strengthened.

[1] Resolution WHA58.27.

- Countries' capacity to carry out medicines-related work will continue to be strengthened and there will be a closer focus on supporting subregional structures.
- Closer collaboration with other WHO programmes, for example HIV/AIDS, organization of health services, tuberculosis and malaria, and with other international agencies at global and country levels will be achieved through intensified activities to coordinate pharmaceutical policies across WHO and between United Nations agencies.

Approved budget and actual expenditure

		Approved budget	Actual expenditure		
			Regular budget	Other sources	All funds
Total 2004-2005 (US$ thousand)		51 447	16 217	33 739	49 956
Percentage	countries	15	34	13	20
	regions	28	24	22	22
	global	57	42	65	58

IMMUNIZATION AND VACCINE DEVELOPMENT

WHO objective(s)

To achieve substantial progress in the areas of: innovation – development of new vaccines, biologicals and immunization-related technologies, made available to countries to reduce the burden of diseases of public health importance; immunization systems – greater impact of immunization services as a component of health delivery systems; accelerated control of disease – control, elimination or eradication of high-priority diseases in ways that strengthen the health infrastructure.

Indicator(s) and achievement

- Coverage of children less than one year of age with three doses of hepatitis B vaccine: 48% covered in 192 Member States.
- Coverage of children less than one year of age with three doses of diphtheria-tetanus-pertussis vaccine: 78% covered in 192 Member States.
- Number of cases of poliomyelitis reported globally: 2039 cases reported in 2003-2004.

Main achievements

- In 2005, in resolution WHA58.15 the Health Assembly adopted a new strategy to fight vaccine-preventable diseases which kill more than two million people each year. The Global Immunization Vision and Strategy 2006-2015, jointly developed by WHO and UNICEF, has four main aims: to immunize more people against more diseases; to introduce a range of new vaccines and technologies; to integrate immunization with other health interventions and surveillance; and to manage vaccination programmes and activities in the context of global interdependence.
- Significant progress was achieved in vaccine research. New vaccines include: two rotavirus vaccines, two meningitis vaccines, a nine-valent pneumococcal conjugate vaccine, two human papillomavirus vaccines protecting against cervical cancer, a malaria vaccine showing 58% protection against severe disease in a Phase II clinical trial, an oral cholera vaccine demonstrating close to 80% protective efficacy in a low-resource setting and a vaccine for Japanese encephalitis. Moreover, 10 priority developing countries made notable progress in their HIV vaccine-preparedness activities.
- In response to a pandemic threat, the WHO Expert Committee on Biological Standardization established new WHO guidelines for the production and quality control of human influenza pandemic vaccines. It also approved the first international standard for a human genetic test.
- Vaccine quality and immunization safety improved. The number of Member States using vaccines of assured quality increased to 179 (93%). Twenty-four (13%) more Member States started using autodisable syringes in routine immunizations (111 (58%) in total). Remarkable progress was made: autodisable syringes are used in 85% of countries in the African Region, 91% (all but one country) in the South-East Asia Region, 41% in the European Region and 45% in the Eastern Mediterranean Region.
- Implementation of the "Reaching Every District" approach helped to improve routine immunization coverage. Globally, immunization coverage with three doses of diphtheria-tetanus-pertussis (DTP3) vaccine was sustained at 78%.[1] Coverage in the African Region increased by 8%, reaching total coverage of 66%. By the end of 2004, 102 countries had attained more than 90% DTP3 coverage, 80 countries had achieved between 50% and 89%, and only 10 countries had a coverage below 50% (compared with 20 countries in 2000).
- Global measles mortality fell by 23% after 2002. The largest reduction was in Africa and the Western Pacific, where estimated measles mortality decreased by 32% and 44% respectively. Africa's results have a critical effect on the global figures, accounting for over 50% of global measles deaths since 2002. Reduction of measles mortality was also documented in the South-East Asia Region, with an 8% decrease, and the Eastern Mediterranean, with 22%. The European Region had a 52% reduction with less than 1000 deaths. The Region of the Americas maintained interruption of measles endemic transmission, with less than 100 cases reported in 2005.
- Although the global goal of eliminating maternal and neonatal tetanus by 2005 was not met, notable progress was made. Twenty-six countries implemented tetanus toxoid supplementary immunization activities in high risk areas, protecting over 17 million women of childbearing age with at least two doses of tetanus toxoid. Nepal, Rwanda, Togo and Viet Nam were validated as having achieved elimination of maternal and neonatal tetanus. In addition, the Indian state of Kerala was validated after a review by an international team.

[1] DTP3 coverage figures based on WHO/UNICEF estimates.

Illustration of selected achievements

- Strong advances made in eliminating poliovirus types 2 and 3 in the remaining poliomyelitis-affected areas led to the development and introduction of two new vaccines. Monovalent oral poliomyelitis vaccine type 1 and monovalent oral poliomyelitis vaccine type 3 offer higher protection against specific virus types than the trivalent oral poliomyelitis vaccine traditionally used. Monovalent oral poliomyelitis vaccine type 1 was developed in record time in 2005, and used for the first time in Egypt and India. Both vaccines are now available to all countries. Monovalent oral vaccines are expected to become the "workhorses" for the final phase of the global poliomyelitis eradication effort in 2006. Already being administered in 10 countries, Angola, Egypt, Eritrea, Ethiopia, India, Indonesia, Pakistan, Somalia, Sudan and Yemen, use of the monovalent oral vaccine type 2 will be dramatically scaled up in 2006, to interrupt transmission of the remaining strains of wild-type poliovirus more rapidly.
- Egypt and Niger stopped indigenous poliovirus transmission, reducing the number of countries in which poliomyelitis is endemic from six to four (Afghanistan, India, Nigeria, Pakistan), the lowest in history. Most of the countries in Africa and Asia that were reinfected during the multicountry epidemic of 2003-2005 are again poliomyelitis-free; and of the eight countries that have yet to halt transmission of the imported virus, Somalia poses the greatest challenge. This progress was the result of the rapid development and introduction of new monovalent oral poliovirus vaccines and improvements in the quality of poliomyelitis-eradication activities, aimed at reaching more children during supplementary immunization campaigns.

Achievement of Organization-wide expected results

Research and development promoted and preclinical evaluation facilitated for new candidate vaccines against tuberculosis, malaria, shigellosis and dengue (in collaboration with the Special Programme for Research and Training in Tropical Diseases) and HIV/AIDS (in collaboration with UNAIDS)

Indicator	Baseline	Target	Achievement
Number of WHO-supported candidate vaccines advancing from preclinical to clinical evaluation or progressing in the clinical evaluation phase	0 of 6	6 of 6	4 of 6
Proportion of WHO support for vaccine research and development allocated to investigators in developing countries	40%	50%	50%

Phase I malaria vaccine trial completed in China with preliminary analysis showing that vaccine is safe and immunogenic. Meningococcal A conjugate vaccine tested in Phase I in India. Leishmaniasis vaccine in Phase II tested in Latin America. Japanese encephalitis vaccine currently in Phase III in Australia. Two trials of measles aerosol vaccine postponed until 2006 to allow for extensive dialogue and coordination with regions (regionalization of activities).

Clinical trials (safety, immunogenicity and efficacy) facilitated for selected new HIV/AIDS, pneumococcal, meningococcal, enterotoxigenic *E. coli*, Japanese encephalitis, rotavirus and human papillomavirus vaccines, and for vaccines against other infectious diseases, where appropriate

Indicator	Baseline	Target	Achievement
Number of early-introducers of vaccines in low- and lower-middle-income countries provided with data supporting evidence-based decisions on introduction of vaccine against pneumococcus, rotavirus or human papillomavirus infection	0 of 34	6 of 34	6 of 34
Number of priority developing countries having progressed with their HIV vaccine-preparedness activities (national plans, training activities, infrastructure strengthening, and/or clinical trials)	0 of 32	10 of 32	10 of 32

Evaluation of safety of neonatal dose of pneumococcal conjugate vaccine completed. Rotavirus vaccine clinical trials completed in Africa and Asia. The African AIDS Vaccine Programme facilitated the initiation of clinical trials of HIV vaccine in Africa and continued to support countries in their preparation for trials.

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

Indicator	Baseline	Target	Achievement
Percentage of population under one year of age living in countries where hepatitis B vaccine has been introduced, and where Hib vaccine has been introduced and a substantial burden of disease exists	44% of infants covered by three doses of hepatitis B vaccine in 192 Member States	58% of infants covered by three doses of hepatitis B vaccine in 192 Member States	48% of infants covered by three doses of hepatitis B vaccine in 192 Member States
	32% of infants covered by three doses of Hib vaccine in 149 Member States with substantial disease burden	40% of infants covered by three doses of Hib vaccine in 149 Member States with disease burden	43% of infants covered by three doses of Hib vaccine in 149 Member States with substantial disease burden

The Western Pacific Region (which accounts for 40% of global hepatitis B mortality) was one of the first regions to set a hepatitis B control target date. All countries in the Region except one introduced hepatitis B vaccine into routine immunization. Twelve (6%) more Member States (including India) fully or partially included hepatitis B vaccine into routine immunization schedules. In total, 153 (80%) Member States introduced the vaccine. Eight (4%) more Member States introduced Hib vaccine into routine immunization – a total of 92 (48%) Member States. Continuous efforts were made in the regions to assess disease burden and the cost-effectiveness of introducing hepatitis B and Hib vaccines. The Hib Initiative was launched, with WHO part of the consortium mandated by the Global Alliance for Vaccines and Immunization.

Updated (or new) guidance on the standardization and control of biologicals finalized and promoted

Indicator	Baseline	Target	Achievement
Percentage of priority biological medicines for which necessary regulatory research is under way or which have production and control recommendations consistent with latest scientific developments	Regulatory research for 4 of 14 biologicals, recommendations for 6 of 16 biologicals	Regulatory research for 14 biologicals, recommendations for 16 biologicals	Regulatory research under way for 13 of 14 biologicals Recommendations under way for 15 of 16 biologicals

Guidelines and recommendations for DNA vaccines, live attenuated rotavirus vaccines (oral), inactivated rabies vaccine, whole-cell pertussis vaccine and materials for Japanese encephalitis antibody reference reagent completed and adopted by the Expert Committee on Biological Standardization. Regulatory research on BCG vaccine initiated. Guidelines completed for dengue vaccine and international reference materials. Work in progress for molecular methods on quality control, guidelines on stability evaluation of vaccines and cell substrates, standards for human papillomavirus, Japanese encephalitis and pneumococcal vaccines. Regulatory research under way on tuberculosis and HIV vaccines.

Adequate support provided for implementing policies and building capacity to assure the sustainable supply and the quality of all vaccines delivered by national immunization services

Indicator	Baseline	Target	Achievement
Percentage of countries where the national immunization system uses only vaccines of assured quality (as per WHO criteria)	174 (91%) of 192 Member States	179 (93%) of 192 Member States	179 (93%) Member States
Percentage of countries that have a budget line for vaccines and syringes	98 (51%) of 192 Member States	115 (60%) of 192 Member States	105 (55%) Member States have budget line for both vaccines and syringes

Revised procedure for vaccine prequalification formulated and enforced. The Developing Countries' Vaccine Regulators Network established to provide a platform for discussion and advancement of knowledge of policies and procedures pertaining to evaluation of new vaccines. Vaccine procurement training centres established in Latvia, Morocco and Sri Lanka. Nineteen international vaccine management, quality and regulation courses conducted in eight other countries. In-country training workshops held in China, India, Indonesia, Islamic Republic of Iran, Thailand and Viet Nam. Review of vaccine production capacity worldwide completed to contribute to the formulation of the supply strategy for new vaccines of the Global Alliance for

Vaccines and Immunization (18 manufacturers in nine countries and five multinational companies surveyed for 12 different vaccines).

Adequate support provided for building capacity in priority countries to implement a comprehensive system to ensure safe immunization injection practices

Indicator	Baseline	Target	Achievement
Percentage of countries assuring sterile immunization injection practices (as per WHO algorithm)	37 (22%) of 165 developing country Member States	132 (80%) of 165 developing country Member States	62 (38%) of 165 developing country Member States

The Global Advisory Committee on Vaccine Safety held four meetings to discuss vaccine and injection safety issues. Standardized tool for measuring injection safety used in more than 80 countries since 2001. Procurement of autodisable syringes by UNICEF increased from 442 million in 2003 to more than 700 million in 2005. Notable improvement made in process for advising countries on the performance, quality and safety of injection equipment. Seventy-two applications for syringes reviewed, with 39 qualifying for supply to countries through organizations and specialized agencies of the United Nations system. Twenty-three (12%) more Member States – a total of 131 (68%) – reported monitoring for adverse events following immunization.

Adequate technical and policy support provided to priority countries to strengthen key immunization functions and managerial capacity at all levels

Indicator	Baseline	Target	Achievement
Percentage of countries monitoring district-level immunization coverage (all routine antigens)	150 (78%) of 192 Member States monitor district-level coverage of diphtheria-tetanus-pertussis vaccine	163 (85%) of 192 Member States monitor district-level coverage of diphtheria-tetanus-pertussis vaccine	152 (79%) Member States monitor district-level coverage of diphtheria-tetanus-pertussis (DTP3) vaccine

All Member States except one reported 2004 immunization data through WHO/UNICEF joint reporting form. In 51 (27%) Member States, all districts achieved over 80% DTP3 coverage. Two "vaccination weeks" conducted in the Region of the Americas with participation of 36 countries, reaching 82 million people. "Immunization week" also piloted in eight countries in the European Region. Comprehensive multiyear plan to consolidate all immunization-related plans developed in collaboration with UNICEF and other key partners. Guidelines released and training programmes organized in the regions and selected countries. Networks established for surveillance of paediatric bacterial meningitis in the Eastern Mediterranean Region and of rotavirus in both the African and Eastern Mediterranean regions. The International Finance Facility for Immunization created to implement an innovative approach to fund-raising. The US$ 4000 to 8000 million raised will be used to increase access to existing vaccines and accelerate introduction of new vaccines.

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

Indicator	Baseline	Target	Achievement
Number of WHO regions certified as free of poliomyelitis	Three of six WHO regions	Three of six WHO regions	Three of six WHO regions

Health Ministers of the remaining poliomyelitis-affected countries signed the Geneva Declaration for the Eradication of Poliomyelitis in January 2004, committing to the intensification and completion of eradication activities globally. The Global Poliomyelitis Eradication Initiative Strategic Plan 2004-2008 launched. More than 25 countries across Africa, the Middle East and Asia resumed mass poliomyelitis immunization activities to halt or prevent further national and international spread of a multicountry epidemic that originated in northern Nigeria.

Despite a marked increase in costs, the funding gap for 2004-2005 activities was closed. The European Region was the first to complete the first phase of laboratory containment of poliovirus. A framework was published for national policy-makers in countries using routine oral poliomyelitis vaccine.[1] The Advisory Committee on Poliomyelitis Eradication was established to guide the eradication "endgame".

[1] *Framework for national policy-makers in OPV-using countries: cessation of routine oral polio vaccine (OPV) use after global polio eradication.* Geneva, World Health Organization, 2005.

The poliomyelitis eradication infrastructure was used to respond to health and humanitarian emergencies worldwide, including the tsunamis in south Asia, the earthquake in Pakistan and outbreaks of avian influenza and Marburg haemorrhagic fever.

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

Indicator	Baseline	Target	Achievement
Percentage of targeted countries consistently implementing strategies to eliminate maternal and neonatal tetanus	29 (51%) of 57 priority Member States	45 (76%) of 58 priority Member States	43 (74%) of 58 Member States that did not achieve the goal of elimination of maternal and neonatal tetanus (denominator includes Timor-Leste) implement strategies to do so
Percentage of endemic countries including yellow fever vaccine in routine measles immunization	29 (74%) of 39 targeted countries	33 (85%) of 39 targeted countries	33 (85%) of 39 targeted countries include yellow fever vaccine in routine measles immunization

Four more Member States achieved goal of elimination of maternal and neonatal tetanus (in total 9 of 58 priority Member States). Survey conducted in Afghanistan to assess baseline incidence of neonatal tetanus. Several planned neonatal tetanus assessments postponed owing to external factors or slower progress than anticipated in programme implementation. Investment case for maternal and neonatal tetanus approved for a total of US$ 62 million by Global Alliance for Vaccines and Immunization. US$ 58 million committed by Global Alliance to control resurgence of yellow fever in West Africa.

Adequate support provided to implement strategies to achieve a sustainable reduction in measles mortality and to interrupt transmission in areas where measles-elimination goals have been set

Indicator	Baseline	Target	Achievement
Percentage of population under one year of age which live in countries where strategies for sustainable measles mortality reduction or for measles elimination are being implemented	59% of population under 1 year of age live in 163 Member States offering second opportunity for measles immunization	72% of population under 1 year of age live in 187 Member States offering second opportunity for measles immunization	64% of population under 1 year of age live in 168 Member States offering second opportunity for measles immunization

One hundred and sixty-eight (88%) Member States offer second opportunity for measles immunization. Ten (5%) more Member States started implementation of the WHO/UNICEF comprehensive strategy for sustainable measles mortality reduction (145 (76%) in total). India, Nigeria and Pakistan continue to present major challenges. Progress achieved in measles and rubella laboratory network expansion and integration with other disease networks (total of 700 measles laboratories in 161 countries). Ninety-three per cent of 116 participating laboratories passed the proficiency test in 2005. The European Region included rubella-elimination goal in its regional strategic plan. One hundred and eighteen (61%) Member States integrated rubella vaccine into routine immunization (one country only partially).

Success factors and impediments

Success factors

- Maintaining technical excellence of support to the regions and countries is critical if progress is to be made in building their capacity.
- Close collaboration between WHO offices and effective engagement of national counterparts is essential. The coordination between country programmes, laboratories and all stakeholders was crucial for early diagnosis and control of poliomyelitis importations and outbreaks.
- Strengthened political commitment of many Member States contributed to countries' progress towards immunization goals.
- Sustained support of partners at all levels for main initiatives remains a key factor in achieving eradication and elimination goals.
- Significant improvements in immunization activities outside the initiatives resulting from increased collaboration and support of partners.

Impediments

- Gap between required and available resources continues to increase at all levels, especially for introduction of new vaccines, vaccine quality and regulation activities, surveillance strengthening, and control and elimination of new diseases.
- Competing priorities between different health programmes against the background of limited resources make immunization and vaccine development activities vulnerable.
- Lack of human resources, high turnover and relatively poor technical and managerial capacities at national and district levels in some countries continue to be major problems.
- Level of government support for certain functions requires improvement.
- Low per capita expenditures on public health coupled with high external dependence in some Member States remains an obstacle.
- Vaccine shortfalls and higher prices for new vaccines adversely affect efforts to increase vaccine coverage.
- Insecurity in certain countries and areas interrupts activities at critical times and limits access and immunization coverage.

Lessons learnt in 2004-2005 and how they will be applied in 2006-2007

- Provision of clear and effective strategies and policies is imperative. Introduction of the Global Immunization Vision and Strategy, and the formulation of regional strategic plans and countries' comprehensive multiyear plans should lead to overall improvement.
- Joint planning and close coordination between headquarters and regional offices has facilitated implementation of activities, and should be sustained.
- The "Reaching Every District" approach helped to improve routine immunization coverage. This effort should be continued.
- Quality and sensitivity of surveillance should be maintained at the highest possible level to allow well-reasoned decision-making, early detection of and timely response to problem situations.
- A good resource-mobilization strategy is needed to ensure adequate and sustainable financial resources. Possibilities of broader cooperation with current partners and donors, and active involvement of new partners and donors, including at country levels, should be explored.
- Effective advocacy and communication are essential to global immunization goals. The strategy for this area should be improved and resources increased.
- Lack of resource, technical and managerial capacity at country and district levels remains a problem. Wherever possible, support to countries for capacity-building should be enhanced through training and regular supervision and guidance.
- The infrastructure created under the poliomyelitis eradication initiative could be used more efficiently to support other disease-control and elimination initiatives. Involvement and integration with other health delivery systems would be beneficial.
- Groundwork for introduction of new and underutilized vaccines, and integration of immunization with other interventions, require early planning and continuous monitoring to facilitate further implementation of activities.
- Vaccine availability should be ensured to continue increasing immunization coverage.

Approved budget and actual expenditure

		Approved budget	Actual expenditure		
			Regular budget	Other sources	All funds
Total 2004-2005 (US$ thousand)		437 146	16 431	671 824	688 255
Percentage	countries	63	27	49	49
	regions	21	26	38	38
	global	16	47	13	13

BLOOD SAFETY AND CLINICAL TECHNOLOGY

WHO objective(s)

To ensure that Member States are adequately equipped to frame, implement and monitor national policies, improve access to safe blood, blood products and health care technologies, and that these are safe, of an assured quality and used appropriately.

Indicator(s) and achievement

Number of countries implementing effective policies, programmes and plans for provision of safe blood products, injections and medical devices and procedures, and their appropriate clinical use. One hundred and sixty two countries reported the development or implementation of effective policies, programmes and plans for provisions of safe blood products.

Main achievements

- Collaboration and partnerships with organizations concerned with global blood safety were strengthened and the network was expanded through the Global Collaboration for Blood Safety. WHO organized a high-level senior health policy-makers' forum at which a consensus statement on good policy process for blood safety and availability was drafted.
- Technical support was provided to Bhutan, Brunei Darussalam, Cambodia, China, Ethiopia, Fiji, Haiti, Indonesia, Lao People's Democratic Republic, Lesotho, Mali, Namibia, Philippines, Rwanda, Sri Lanka, United Republic of Tanzania and Viet Nam to develop national blood programmes based on well formulated national blood policies and plans. The information generated from the global database on blood safety 2001-2002 was used to identify country needs in order to strengthen blood transfusion services.
- WHO played a catalytic role in mobilizing resources for Bangladesh, Cambodia, Democratic People's Republic of Korea, Ethiopia, Haiti, Indonesia, Namibia, Sri Lanka and Timor-Leste for strengthening national blood transfusion services through the Government of Luxembourg, the European Union, the World Bank, the Global Fund to Fight AIDS, Tuberculosis and Malaria, Japan Bank for International Cooperation and the President's Emergency Plan for HIV/AIDS Relief (United States of America). Technical assistance was provided to strengthen blood transfusion services, especially to countries emerging from complex disaster situations, such as Afghanistan and Iraq.
- Capacity building for voluntary donor recruitment was conducted jointly with the International Federation of Red Cross and Red Crescent Societies through cascade training in more than 60 countries, with more than 180 participants; training in blood cold-chain maintenance was given to more than 90 participants from 40 countries with support from the Government of Luxembourg; ongoing quality management training was provided through eight regional and/or national training courses; 20 quality auditors from 15 countries were trained; follow-up visits were made and quality systems in blood transfusion programmes were strengthened in 25 countries; advanced regional quality management training courses for blood transfusion services were organized, attracting 24 participants from 11 countries; and training was provided on the establishment of systems for appropriate and safe clinical transfusion to 178 participants from 14 countries.
- The newly created clinical procedures team consolidated work on emergency and essential surgical care at first-referral hospitals, producing an integrated management package for policy-makers and care providers. It also developed a standardized and cost-effective approach to capacity building in countries through cooperation between health authorities and nongovernmental organizations. Work commenced towards the establishment of a global initiative for emergency and essential surgical care, following growing recognition of its impact on Millennium Development Goals 4, 5 and 6.
- Disaster response was improved through collaboration on enhanced training of health providers in emergency and essential surgical skills, appropriate use of blood and development of guidelines adapted to local needs. Following the December 2004 earthquakes and tsunamis, a unified information and communications technology project in Sri Lanka was launched in collaboration with the World Bank.
- Pursuant to resolution WHA57.18 on human organ and tissue transplantation, work was initiated to ensure suitable, safe and effective transplantation, with due regard for the dignity of donors and recipients.
- Support was provided to assess the injection safety situation, to develop policy and to adopt various intervention programmes to improve injection safety and related infection control. Assessments were carried out in Cambodia, China, Fiji, Kiribati, Lao People's Democratic Republic, Mongolia and Viet Nam. WHO collaborated with industry and partners to devise an improved system for the prequalification of injection devices, building on the success of the 25-year-old product information sheet system for immunization equipment and devices. The WHO/UNICEF performance, quality and safety standards for the prequalification of autodisable syringes for immunization and reuse-prevention features for curative devices came into operation in June 2005. More than 70 product dossiers on injection safety were reviewed and 39 products approved by 30 July

2005 (in time to meet the UNICEF Supply Division tender date). Self-financing of the system begins with the receipt of dossier review fees.

Illustration of selected achievements

- Resolution WHA58.13 established World Blood Donor Day, 14 June, as an annual event. It was observed in more than 75 countries in 2004 and in more than 90 countries in 2005.
- Minimum requirements for the safety of essential human cell and tissue products for transplantation were identified. Capacities of health providers at first-referral health-care facilities for emergency and essential surgical procedures were strengthened through training workshops in Ethiopia, Ghana, Kyrgystan, Maldives, Mongolia, Mozambique, Pakistan and Viet Nam.
- Technical guidance was provided in diagnostics and laboratory technology to strengthen national capacity for regulating and monitoring the quality of diagnostics, in particular HIV tests. This is important given the quantity of locally-produced test kits in China. A multi-partner mission representing WHO, UNICEF, UNAIDS and the Clinton Foundation HIV/AIDS Initiative, together with a representative of the Chinese Ministry of Health, provided technical input for the national approach for scaling up HIV prevention, treatment and care for adults and infants; WHO provided logistic support in developing diagnostics and laboratory requirements.

Achievement of Organization-wide expected results

Support provided to countries to frame, implement and monitor the impact of national policies for blood and blood product safety, injection and medical devices, safety, and laboratory and diagnostic services

Global collaboration and partnerships strengthened to improve access to safe blood and clinical technologies

Indicator	Baseline	Target	Achievement
Percentage of targeted countries with effective policies and the necessary legislative framework to ensure safe and appropriate use of blood, blood products, injections and medical devices, and laboratory and diagnostic services	2002 data indicate that in 145 countries a national blood policy had been developed or implemented	24 additional countries reported having developed a national blood policy	17 additional countries
Number of effective global collaborations and partnerships to improve safety of blood and blood products, injections, and medical devices and procedures	10 meetings, trainings and material development	20 additional collaboration initiatives	20 additional collaboration initiatives
	No global collaboration in the field of emergency and essential surgical care procedures	1 meeting towards global initiative on Emergency and Essential Surgical Care, training in countries, tool development	1 meeting towards global initiative

In relation to diagnostic and laboratory technology, collaboration was strengthened with key partners, including UNAIDS, UNICEF, the World Bank, UNFPA, Médecins Sans Frontières, the Global Fund to fight AIDS, Tuberculosis and Malaria, the Clinton Foundation HIV/AIDS Initiative, the Centers for Disease Control and Prevention, Atlanta, Georgia (USA), International Union against Tuberculosis and the World Association of Societies of Pathology and Laboratory Medicine. At least five meetings were held with most of these partners.

WHO was instrumental in establishing the International Association for Safe Injection Technology and in setting up a working group of the International Organization for Standardization on new standards for safe injection devices.

In Viet Nam, project management units were established and staffed and various technical supports provided for implementation of the regional blood transfusion centre project. Support was also provided to: strengthen the national blood services in Bhutan, Indonesia, Lao People's Democratic Republic and Sri Lanka; prepare a framework for implementing reform of the blood services (with funds from various sources); and develop and implement policy for nationally coordinated blood transfusion services in Brunei Darussalam, China, Fiji and the Philippines. National policy analysis was carried out in nine Member States in

the European Region. Three Member States formulated a draft blood policy. Bangladesh, India, Nepal and Thailand already have policies in place.

Guidance provided on procurement management and increasing the affordability of essential equipment, diagnostic technologies, and injections and medical devices

Support and improved access to new technology appropriate for resource-limited settings

Guidance provided on blood-donor recruitment and stock management

Indicator	Baseline	Target	Achievement
Dissemination of procurement-management guidelines	Available in 5 countries	To be available in 8 countries	Prequalification standards for injection devices available for all Member States online
Percentage of savings made through bulk procurement	30% to 50%	50%	Between 50% and 77%
Number of new technologies supported	1: haemoglobin colour scale	1 new: blood cold-chain box promoted in at least 1 country in 6 regions	Workshops on safe use of blood cold chain held in 3 countries
	Emergency surgical care and district hospital services available in all regions	Additional integrated toolkit made available	4 countries implemented and incorporated WHO's new integrated management for emergency and essential surgical care toolkit in education and training programmes
	No affordable digital X-ray equipment	1 system made available for all Member States	1 system made available for all Member States
Percentage of targeted countries with documented blood-donor recruitment and stock-management systems	39 countries	45 countries	45 countries

Prequalification standards for injection devices were made available online, disseminated via regional contacts, used in the South-East Asia Region to support the Indian Government's tender and used by WHO/PAHO in tender specifications. Devices with reuse-prevention features were supported by the creation of an ISO standard and WHO prequalification of devices.

Access to good prequalified diagnostics at reduced prices increased through the United Nations bulk procurement scheme. WHO and UNICEF facilitated the purchase of about 2.6 million HIV test kits in 2004. WHO provides the technical guidance and feedback in this field for all United Nations agencies.

Resolution WHA58.13 was adopted, establishing World Blood Donor Day, 14 June, as an annual event. World Blood Donor Day 2004 was celebrated in more than 75 countries, and in 2005 was observed by more than 90 countries. Support was provided to Cambodia, Lao People's Democratic Republic, and Philippines to celebrate World Blood Donor Day; one regional and three national trainers' training workshops were organized on blood donor recruitment. Training was also organized in China at the provincial level. Support was provided to Vanuatu to develop its voluntary blood donor recruitment programme.

International norms, standards, procedures and biological reference preparations produced and promoted for blood products and related biological substances and in vitro diagnostic procedures

Support for capacity building of national regulatory authorities

Indicator	Baseline	Target	Achievement
Proportion of targeted countries with competent authorities for the control of blood products and related biological substances, in vitro diagnostic procedures, medical devices and procedures	85 global measurement standards already established	8 new or replacement standards established and 2 new guidance documents	National methodological bodies established/considered for implementation in 8 countries in central and eastern Europe
	0 in the field of clinical and surgical procedures	1 standard guidance document for capacity building	8 countries established national bodies to implement best practices in emergency and essential surgical care for a standardized training methodology
Number of WHO international biological reference preparations produced and promoted	0	At least 10 national regulatory authorities supported	WHO guidelines disseminated to national counterparts in 52 Member States

The safety and efficacy of blood products and related in vitro diagnostic procedures rely on validated quality assurance systems. National regulatory authorities and manufacturers in Member States face two challenges in ensuring the quality and safety of these products: the risk of contamination through blood-borne pathogens and difficulties in validating quality-assurance systems owing to the inherent variability of biological products.

Adequate technical and policy support provided for validation of new tools and strategies for blood safety, diagnostic support, injection and medical devices safety

Indicator	Baseline	Target	Achievement
Number of new tools and strategies validated	0	12	12
Number of countries and partners using technical information and guidelines	0	16	22 countries. A number of advocacy activities exposing countries to new guidelines, recommendations and technical information

Draft guidelines for prequalification of HIV/AIDS technologies, including HIV tests, and CD4 and viral load technologies were developed and are under review; statement on early diagnosis of HIV infection in exposed infants was also prepared.

A guide to selection and procurement, and a manual on management, maintenance and use of blood cold-chain equipment were prepared and disseminated to all regions. A structured training-of-trainers module, developed jointly by WHO and the International Federation of Red Cross and Red Crescent Societies for cascade training of donor recruiters, was evaluated in China and Singapore. WHO guidelines on establishing external quality-assessment schemes in blood group serology were published.[1] A French version is now available and a Chinese version is in preparation.

[1] *External quality assessment of transfusion laboratory practice: guidelines establishing an EQA scheme in blood group serology*. Geneva, World Health Organization, 2004.

Quality-management systems strengthened; and external quality-assessment schemes promoted for laboratory and blood-transfusion services

Indicator	Baseline	Target	Achievement
Proportion of targeted countries having implemented quality-management systems for laboratory and blood transfusion services	40 national reference laboratories and blood transfusion services	60	60
Performance and number of laboratories and blood-transfusion services participating in external quality-assessment schemes	60% acceptable performance	65% acceptable performance	75%

With more than 100 high-level professionally trained managers, national reference laboratories and blood transfusion services implemented improved quality-management systems. Training and technical support were provided to countries for building capacity in quality management in order to establish quality systems in the blood transfusion services. A quality management training facilitators' toolkit, also supplied on an interactive CD-ROM, and effective quality networks and quality network newsletters were developed. An advanced quality management training course for blood transfusion services attracted 24 participants from 11 countries. Four quality management training courses were held and more than 80 professionals trained in quality management in the European Region. Support was provided to six countries in organizing national quality-management training courses; 18 countries initiated the quality management process in blood transfusion services; follow-up visits were made by quality management experts to Lao People's Democratic Republic, Mongolia, and Papua New Guinea. Support was provided to 17 countries to upgrade their national external quality assessment scheme programmes and technical support was also provided for quality assessment schemes for blood group serology; a workshop on strengthening blood safety and laboratory services in the Western Pacific Region was attended by 21 people from 13 countries.

External quality-assessment schemes were provided for a variety of laboratory markers, including those of HIV and hepatitis B and C virus infections, CD4 immunophenotyping, haematology, parasitology, clinical chemistry and coagulation. On average, performance of laboratories increased after participation in three consecutive distributions of external quality assessment materials. Regional centres of excellence became operational in most WHO regions and provided support to poor performers. Guidelines to ensure good laboratory practice, technical information sheets and maintenance guidelines for basic laboratory tests at the district level were distributed. Translations into other WHO official languages are in preparation.

Technical support provided for building capacity to improve the appropriate, safe and cost-effective use of transfusion therapy, injections, diagnostic imaging and radiation therapy, laboratory and diagnostic services, and medical devices and procedures

Indicator	Baseline	Target	Achievement
Number of countries using WHO training materials, guidelines and recommendations for building capacity in diagnostic imaging and radiotherapeutical practices, equipment maintenance and waste management, blood transfusion and laboratory and diagnostic services, emergency and surgical procedures	0	12	35 countries
Proportion of targeted countries with documented safe and appropriate use of blood and blood products	10	15	15 countries
Proportion of targeted countries practising safe and appropriate use of injections	0	2	19 countries

Technical support was provided for building capacity in the clinical use of blood to ensure the appropriate, safe and cost-effective use of transfusion therapy. An intercountry workshop to develop mechanisms for ensuring safe and appropriate use of blood was attended by 28 participants from 10 countries. Support was provided to Papua New Guinea to develop national guidelines for clinical use of blood, and evaluate nationwide diagnostic imaging services, and to the Democratic People's Republic of Korea to evaluate diagnostic imaging services and identify measures for improvement. One new centre of excellence for education and training in diagnostic imaging was established in Cameroon.

Regional workshops were held in all regions to pilot and review training materials for HIV rapid testing and CD4+ cell count technologies. Several countries are now developing their own implementation plans. The training materials and manuals are being translated into additional languages.

Success factors and impediments

Success factors

- National authorities showed increased interest and commitment to improve blood safety.
- WHO's presence in countries at a time of strong political will enabled WHO to play a stronger policy-guidance role.
- Enhanced information exchange and networking between professionals and institutions in the field, at global, intercountry and national levels, and increased awareness, interest and support of national authorities and global partners led to establishment of global initiatives (on surgical care procedures, for example) and centres of excellence (for diagnostic imaging).
- Events such as World Blood Donor Day increased visibility and raised awareness of blood donations, the need for action, and the role of WHO.
- Continuous advocacy, communication and networking with governments and other partners and continued collaboration with scientific and professional bodies led to better global practice references; collaboration with The Transplantation Society, for example, resulted in global consensus on the care of the live kidney donor.
- Practical training manuals were produced.
- First low-cost computer radiography system was successfully tested.
- Countries' commitment to provide antiretroviral therapy with generic drugs emphasized the need for strengthening laboratory infrastructure.

Impediments

- Despite the continuing concern for blood safety at the global level, this area was affected by a serious shortage of human resources and lack of stable funding to meet the targets and expected results at global, regional and country levels, and to ensure adequate follow-up of activities.
- At country level, weak infrastructure was a major impediment in implementing quality systems in blood transfusion services.
- Political and legal complexities in reforming the current blood system delayed progress in some countries.
- The promulgation of laws on transplantation was delayed in some countries where a profit-making transplant tourism industry has emerged.
- Instability of decision-making mechanisms had a direct impact at country level on the recognition of national blood safety counterparts.
- There was a lack of validated data collection and management (databases and records) systems on blood safety at national level.
- The infrastructure for implementing quality systems in health laboratories was weak. Laboratory-based monitoring of antiretroviral therapy is a new area that demands sophisticated equipment and skilled manpower. In addition, the laboratory aspects are addressed by different WHO programmes.

Lessons learnt in 2004-2005 and how they will be applied in 2006-2007

- Developing synergies with international stakeholders will assist in joint activities and avoid duplication of efforts and wastage of resources. Efforts will therefore be made in 2006-2007 to develop and implement joint activities with nongovernmental organizations.
- Global campaigns, such as World Blood Donor Day, are an efficient and cost-effective strategy for raising awareness and maintaining the momentum of the blood safety programme. Constructive use of media opportunities during major WHO events, such as World Blood Donor Day and World Alliance for Patient Safety Day, will advance WHO's work.
- Transparency of transplantation activities fosters trust and encourages safe donations. It discourages exploitation of poor and vulnerable populations in transplant tourism and trafficking in human material for transplantation. In 2006-2007, Member

States will be encouraged to ensure transparency in transplantation activities, as one of the key requirements for safety, efficacy and ethics.

- Improved supervision of and support for national counterparts are required to ensure consistency of product delivery at local and national levels. Effective monitoring and evaluation will therefore be carried out to support counterparts in the coming biennium.
- Increased visibility of the blood safety programme is a prerequisite for stable funding for implementation of the work plan. Advocacy efforts will therefore be stepped up through international partnerships, networking and collaboration.
- WHO blood safety, laboratory, injection safety and clinical procedures programmes should be linked with disease-control programmes, such as on HIV/AIDS. However, the need for systems to ensure sustainable improvement should always be kept in mind in programme development and implementation.

Approved budget and actual expenditure

		Approved budget	Actual expenditure		
			Regular budget	Other sources	All funds
Total 2004-2005 (US$ thousand)		24 635	12 980	9 248	22 228
Percentage	countries	30	35	20	29
	regions	19	25	21	23
	global	51	40	59	48

EVIDENCE FOR HEALTH POLICY

WHO objective(s)

To improve the performance of health systems by the generation and dissemination of evidence, to build capacity to use this evidence, and to provide support for national and international dialogue on ways to improve health systems' performance.

Indicator(s) and achievement

- *Availability of practical tools to help policy-makers and health professionals to analyse health situations and systems and formulate national policies for improving the performance of health systems.* Practical tools have been developed and are now being used in areas critical to the development of health systems
- *Strengthened ability of countries to adapt and use these tools in their own settings.* Many countries now have additional capacity to use tools and the information provided by them for policy purposes.
- *Existence of functioning networks with regional and national institutions and active partnerships with international agencies supporting the analysis and development of more effective stewardship, financing, and resource generation and provision in countries.* Regional and global networks now exist for different activities, and there is increased collaboration with multilateral and bilateral partners.

Main achievements

- Data sharing was intensified: data from the World Health Survey was prepared and provided to countries for analysis, as well as being made available online; databases on health expenditures, mortality, and human resource availability were updated and published online and in world health reports; the WHO CHOICE project now provides region-specific estimates of the costs and effects of more than 800 interventions.
- National health information systems were strengthened, some through interaction with the Health Metrics Network. The Health Metrics Network framework is being used by countries and development partners to align activities associated with the generation, analysis and use of health statistics. Forty-one countries received catalytic funding from the Network to begin strengthening their national health information systems.
- Further progress was made in helping countries to attain the goal of universal coverage of basic health services with the adoption by the Health Assembly of a resolution on sustainable health financing, universal coverage and social health insurance in May 2005.[1] A strategy on health care financing for countries of the Western Pacific and South-East Asia regions was adopted by the Regional Committee for the Western Pacific.[2] Technical support was provided to countries wishing to modify their financing systems in all regions.
- Information dissemination was supported through the world health and European health reports and publications in scientific literature, including a series on the cost-effectiveness of interventions to achieve the Millennium Development Goals and publications on catastrophic expenditures, efficiency of health facilities in Africa, and bioethics committees in the African Region.

Illustration of selected achievements

As more resources become available for health, partly to help countries reach their health-related Millennium Development Goals, it is becoming increasingly important to track funds in a structured and systematic way both for policy development and to assure transparency and accountability. WHO has promoted the development of national health accounts in countries and provided normative guidance. *The Guide to producing national health accounts – with special applications for low-income and middle-income countries* (produced jointly with the World Bank and USAID) was translated into the six official WHO languages. Over 100 Member States have now completed at least one exercise on comprehensive tracking of health expenditures. Technical assistance was provided to a number of countries to undertake first or repeat exercises in tracking health expenditures. Work also started on disease-specific resource tracking for the health-related Millennium Development Goals with some countries preparing accounts for child health, reproductive health, malaria, tuberculosis and HIV. Partners have included UNAIDS, the United States Agency for International Development, the World Bank, the Swedish International Development Cooperation Agency and OECD.

[1] Resolution WHA58.33.

[2] Resolution WPR/RC56.R6.

Achievement of Organization-wide expected results

Validated framework and practical policy tools used to support expansion of capacity of national health systems to obtain, analyse and use critical information, including that on health, responsiveness, fairness of financial contributions, risk factors and the costs and effectiveness of important interventions

Indicator	Baseline	Target	Achievement
Availability and regular updating of databases and other practical tools to help policy-makers and health professionals to analyse health situations, major health outcomes, systems and possibilities for intervention	Databases on health accounts, deaths, disability-adjusted life years and human resources for health available	Update available databases and develop new ones on cost-effectiveness, and catastrophic expenditures and service availability	Databases updated, and cost effectiveness and catastrophic expenditure databases established. Service availability mapping commenced.
Strengthened ability to adapt the framework and tools to their own settings in selected countries	Limited capacity to measure deaths, expenditures and the number and mix of health workers	Strengthened capacity in 20 countries	Capacity strengthened in more than 50 countries

National health accounts and mortality databases were maintained, updated annually and published in the world health reports and online, and trend data are now available. New estimates of the under-five child mortality rate and its causes were produced in collaboration with partners. The mortality and population database and the regional core health database for the WHO Region of the Americas were updated annually. This has led to country initiatives in at least 21 Member States and the preparation of multiple health situation analyses, including those for the report on progress towards achieving the Millennium Development Goals, and subregional health profiles for Central America. The national health system profiles for all countries in the South-East Asia Region were updated and training on the use of the data was supported. Library services were upgraded in 10 countries. Country health system profiles and regional databases in the Regional Office for the Western Pacific were updated, and training in information use for policy analysis for provincial health leaders took place. The Regional Office also published guide books for country use to promote best practices and a logical approach to the design of national health information systems. An extensive database on the costs and effectiveness of health interventions is also available online, as is the global atlas of the health workforce.

The Health Metrics Network framework describes the standards and processes for country health information systems and represents a core support structure around which countries and development partners can coalesce and align their resources. The framework is linked to an assessment tool that enables countries to evaluate the quality of health statistics and identify major gaps and weaknesses to be addressed. The framework was tested in pathfinder countries and the prototype editions were used to generate country health information system profiles in six countries. A series of technical consultations led to a consensus on standardization of the questionnaire and tools to improve comparability of verbal autopsy results.

National and international networks and partnerships in operation for epidemiological estimates and methods, monitoring of major health system outcomes, economic analysis, measurement of health system efficiency and international classifications

Indicator	Baseline	Target	Achievement
Existence of functioning networks with regional and national institutions for devising methods of obtaining estimates on crucial health-policy parameters and ways to use them at national and subnational levels	1 global and 2 regional networks on health accounts Global network on classifications	Develop additional network on health economics and financing in African Region Develop global network on health metrics	Existing networks supported and the African Health Economics Advisory Committee network and the Health Metrics Network established. WHO Family of International Classifications network expanded in Africa, Asia and Latin America

Indicator	Baseline	Target	Achievement
Elaboration and use of mechanisms to promote access to and exchange of comparable data on health systems by countries and WHO	Some, but limited, country access to WHO databases through the portal for WHO's statistical information system and the global atlas of the health workforce	Improved access through updated web sites and dissemination Sites upgraded for national health accounts, cost-effectiveness, international classifications and the World Health Survey	Existing web sites were updated and new, user-friendly sites prepared as targeted World Health Survey data and reports started to be put online Country reports prepared and circulated

Support to existing networks was maintained and country reports were prepared on catastrophic payments, health expenditures and the World Health Survey. Web-based publication was carried out of updates of existing classifications, initiation of revision of the International Classification of Diseases, prototype testing of classification of interventions, in addition to print publication of key information in the world health reports and publications such as *World health statistics 2005*[1] and *The European health report 2005*.[2] There was continuing support for implementation of the Tenth Revision of the International Classification of Diseases in the Regional Office for Europe, and related training was provided in eight Member States. The network of collaborating centres for the WHO Family of International Classifications was strengthened and the designation of new centres was initiated in Africa, Asia and Latin America. An International Classification of Diseases implementation database was compiled to guide capacity-building efforts in countries. This will also inform the Eleventh Revision of the Classification. A standard for comparison of hospital discharge data was defined and subsequently adopted by several countries together with OECD and Eurostat. The first adaptation of the International Classification of Functioning, Disability and Health for children and youth was completed, translated and issued in over 30 languages, and articles were published in various peer review journals. Field tests are in progress in some 70 countries for an international classification of health interventions.

There was a comprehensive assessment of national health information systems in 10 countries, providing a background for further improvements. Enhanced analytical tools and training activities are being developed within the context of work on health analysis and information systems. The African Health Economics Advisory Committee was fully constituted and held its first meeting in November 2004, at which a strategic health economics plan for the African Region was produced for the period 2006-2015. The Regional Office for the Western Pacific collaborated with the Health Metrics Network and ministries of health to devise ways of strengthening country health information systems. Networks on national health accounts exist in the South-East Asia and Western Pacific regions, while there is extensive collaboration between WHO, OECD, the World Bank and some bilateral agencies in this area. WHO collaborates with many agencies, in particular ILO, the German Agency for Technical Cooperation, the Swedish International Development Cooperation Agency, the United States Agency for International Development, the World Bank and OECD on various aspects of health system financing.

[1] *World health statistics 2005*. Geneva, World Health Organization, 2005.

[2] *The European health report 2005: public health action for healthier children and populations*. Copenhagen, WHO Regional Office for Europe, 2005.

Norms, standards, terminology and methods for use by national decision-makers determined and validated on main issues, including population health, responsiveness and fairness of financial contributions and their measurement, international classifications, economic efficiency, economic cost, ethical implications of resource allocation and cost-effectiveness analysis for choosing efficient mixes of interventions

Indicator	Baseline	Target	Achievement
Availability of selected norms, standards, terminology and methods to meet high-priority needs of countries and regions for producing evidence on which to base health policy	Norms and standards available for national health accounts and international classifications of diseases and of functioning, disability and health Guidelines on functional job analysis	Norms, methods and guidelines for cost-effectiveness, catastrophic expenditure and human resources for health Prototype tested of an international classification of health interventions	Guidelines for undertaking cost-effectiveness studies; methods for measuring the proportion of households suffering financial catastrophe because of health payments, and related impoverishment; guidelines developed on the rapid assessment of human resources for health, and on the development of the health workforce in post-conflict situations Prototype tested of an international classification of health interventions
Strengthened ability of targeted countries to obtain and use this information in a way that complements existing routine statistical information systems	Many countries have limited capacity to apply existing norms and standards	Technical support and capacity building to at least 20 countries	Support provided to more than 30 countries

Methodological guidelines on health analysis and information systems are being developed and disseminated for public health surveillance and health situation analyses and to support the development of health information systems. Training in the tenth revision of the International Classification of Diseases was provided. WHO contributed to the definition of a new standard for storage, maintenance and representation of classifications set by the European Committee for Standardization and the International Organization for Standardization. Methods for tracking expenditures were published in the six official languages in a guide to producing national health accounts in low-income countries.[1] Methods for undertaking costing studies were also devised, and strategies for estimating the economic consequences of disease are being prepared.

An evidence base available to guide policy recommendations on critical areas including health care financing, stewardship, resource generation and service provision

Indicator	Baseline	Target	Achievement
Finalization of WHO policy on health system financing	No WHO policy	Policy developed	Policy finalized (resolution WHA58.33 and the strategy on health care financing for countries of the Western Pacific and South-East Asia Regions adopted in Resolution WPR/RC56.R6)
Availability of collected evidence on approaches to stewardship, resource generation and service provision	Only limited availability of this evidence in WHO	Knowledge base on innovative approaches to service delivery improved	Studies to develop and disseminate knowledge where it is lacking developed, e.g. on innovative strategies for improving health services and strengthening health systems completed in 12 low-income countries; country case studies on the effectiveness of health system management completed
Strengthened ability in selected countries to analyse and apply such evidence in national policy development	Some countries with limited capacity in this area	Strengthened capacity in at least 10 countries	Capacity strengthened in 30 countries across all regions

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

A study on the impact of innovative strategies in improving health services and strengthening health systems was completed in 12 low-income countries and dissemination workshops were held. Three country case studies on the effectiveness of health system management were completed. Guidelines on tracking resource availability and deployment were disseminated, and training courses on information use to integrate evidence into policy development were organized in selected countries. In collaboration with the World Bank Institute, seven "flagship" training courses were conducted in the European Region on health sector reform and sustainable financing and poverty, equity and health systems; four were regional, two subregional, and one was national. In the African Region, reports were prepared on the Kenyan and Nigerian social health insurance programmes, and on the cost of safe motherhood programmes in Ghana and Nigeria. A joint strategy for health care financing was developed in the South-East Asia and Western Pacific Regions, and an assessment of health financing systems in a number of countries was carried out. A resolution on sustainable health financing, universal coverage and social health insurance was adopted by the Health Assembly in 2005 and provides the basis for WHO's work in that area. Technical support for health financing policy was provided to more than 30 countries, while workshops or seminars were held for east African and French-speaking countries in the Eastern Mediterranean Region. The European Observatory on Health Systems and Policies published two books on health financing and regulation in Europe and accompanying policy briefs.

Operational mechanisms and validated tools available for updating information regularly and facilitating routine analysis of national and subnational health systems' performance; strategies to improve performance of health information systems in different settings formulated and operational, supporting and complementing routine statistical systems

Indicator	Baseline	Target	Achievement
Availability and use of practical tools for health systems' performance assessment at national and subnational levels, with special attention to resource-poor settings	Limited costing tools available First version of a simulation tool to examine the financial implications of extending financial risk protection developed	Costing tools for scaling up interventions and for disease and programme specific costing Tools for disease-specific resource tracking Simulation tool finalized	Costing and disease tracking tools developed Simulation tool tested and a new version developed, disseminated and used in countries
Formulation of agreed strategies for strengthening health information systems in order to obtain more timely and relevant information for national policy-makers	Existing strategies largely a function of individual disease-focused programmes, lack of overall integration	Health Metrics Network framework universally adopted as global standard for health information system development	Health Metrics Network assessment tools developed and used in low- and middle-income countries
Continued development of the World Health Survey instrument with involvement of countries and international experts	World Health Survey undertaken in 70 countries	Analysis, policy use and continued development of World Health Survey	The World Health Survey instrument was refined and is being implemented in national health surveys
Availability of data from the World Health Survey as public goods to national and international communities	No country data available	Work with countries to finalize analysis and put into public domain	Data from the World Health Survey was prepared and provided to countries for analysis. Results have been made available on the web. Data sets will be released in a phased manner beginning in April 2006

Work on health analysis and information systems has been carried out in coordination with several regional and global initiatives, for example the Health Metrics Network, to strengthen country health information systems including through the development of reference frameworks, assessment methodologies and instruments. The health system performance assessment at subnational level was published in Indonesia and will be disseminated to countries of the South-East Asia Region for their consideration. A biregional strategic framework for strengthening health information systems in Asia and the Pacific was formulated and five countries in the region have conducted the World Health Survey. In Indonesia, the national health survey 2004 was revised to

include methods used in the World Health Survey. A series of intercountry workshops in Africa, Asia/Pacific, Eastern Mediterranean, Latin America and Europe, provided opportunities for the Health Metrics Network framework to be shared widely among countries and development partners. Data from the World Health Survey, which was conducted in 70 countries, was processed and provided to countries for analysis. Two workshops were held to assist 18 countries in the African Region with data analysis and the preparation of reports. Tables from the World Health Survey are now available on the web site. The instrument used for the World Health Survey has been refined and is being implemented in national health surveys in the member countries of the Gulf Cooperation Council, including Yemen. It has also been adapted for use in WHO's Study on Global Ageing and Adult Health, and modules have been used in the Survey of Health, Ageing and Retirement in Europe, funded by the European Commission. WHO is working with Eurostat and the United Nations Economic Commission for Europe on a common instrument for measuring health states based on the World Health Survey.

Practical planning tools for policy-makers that support the implementation of alternative policies and strategies for improving health systems' performance designed and validated

Indicator	Baseline	Target	Achievement
Availability of selected practical tools for policy-makers to use in national policy and planning, within WHO framework	Limited availability of practical tools for country policy makers	Develop or adapt country tools for district and national level decisions	WHO CHOICE country contextualization tool for priority setting Guidelines for district-level planning in African Region Country costing tools adapted from global tools
Incorporation of these tools into policy process in selected countries	Limited use of tools in countries	Tools applied in 10 countries	Tools applied in 18 countries

In the African Region, the country office in Namibia developed health economics guidelines for use in planning at district level, which were then applied. In the South-East Asia Region a health system profile template was developed to assist countries in national policy-making and planning. Six countries in the Region developed databases or essential health indicators at the national or subnational level. The simulation tool for estimating the financial impact of changes in health financing systems was further refined in collaboration with the German Agency for Technical Cooperation and tested in a number of settings. An increasing number of countries are reporting health expenditures regularly and using them for policy purposes. The WHO CHOICE regional database was adapted to provide a country contextualization tool for priority setting. Costing tools were developed, refined and used to estimate the costs of scaling up key interventions, the resource requirements to reduce shortages in human resources, and to develop applications for funding to the Global Fund to Fight AIDS, Tuberculosis and Malaria. Working in collaboration with Health Metrics Network partners, a number of tools were developed to support evidence-based policy-making, including the Network framework and assessment tool, the tool to support enhanced synthesis, analysis and use of country evidence and the Network planning tool. Tools were also designed to enable district health managers to generate improved data on the spatial distribution of health interventions, services and inputs, including human resources, infrastructure and equipment.

Evidence base available to guide the development and implementation of pro-poor health policies and health-related interventions in line with poverty reduction strategies and the Millennium Development Goals

Indicator	Baseline	Target	Achievement
For all countries in the poverty-reduction strategy process: • availability of scientific evidence on what constitutes pro-poor health policies and interventions • ability to analyse national policies from an evidence-based pro-poor health perspective in targeted countries	WHO engaged in limited support to national processes associated with the Millennium Development Goals/Poverty Reduction Strategy Papers	Support to 6 countries under the Poverty Reduction Strategy Papers process	7 countries supported in the Poverty Reduction Strategy Papers/Millennium Development Goals/medium-term expenditure framework process

The Commission on Social Determinants of Health began its work. WHO contributed substantially to work carried out by the United Nations Economic and Social Council, the Brussels Programme of Action for the Least Developed Countries for the Decade 2001-2010 and the World Bank/International Monetary Fund Poverty Reduction Strategy Papers review and the

elaboration of a framework to support national processes. In the South-East Asia Region, workshops on health-related development goals were conducted in five countries. Ten out of 11 countries in the Region submitted reports on their progress towards achieving such goals. Countries in the Western Pacific Region have been advised to disaggregate data by sex and spatial and socioeconomic levels to show inequalities, particularly in health-related Millennium Development Goal indicators. With the support of United Nations country teams, most countries have produced Goal reports to track progress against the targets.

Success factors and impediments

Success factors

- Government commitment as evidenced by the adoption of the resolution on sustainable health financing, universal coverage and social health insurance.
- Improved tools, methods and databases, providing evidence for country decision-making, combined with capacity building and technical support on their use.
- Increased collaboration between different levels of the Organization and with international partners.

Impediments

- Financial restrictions were an impediment for all activities, and requests for country technical support exceeded the capacity to provide it.
- Low investment in the generation, dissemination and use of evidence for health in some countries due to competing needs and priorities.

Lessons learnt in 2004-2005 and how they will be applied in 2006-2007

- More attention needs to be focused on country adaptation of tools and information.
- It is difficult to attract specified extrabudgetary contributions for this activity, which many donors feel is a core WHO activity. It will be necessary to encourage donors to invest more in this international public good.
- Despite increased international funding for priority programmes in countries, many had difficulty scaling up because of health system constraints, including the lack of information and the underdevelopment of health financing systems. Greater attention will be placed on developing synergies between the activities of priority programmes and health systems activities.

Approved budget and actual expenditure

		Approved budget	Actual expenditure		
			Regular budget	Other sources	All funds
Total 2004-2005 (US$ thousand)		80 606	29 252	29 915	59 167
Percentage	countries	37	27	3	15
	regions	27	33	34	34
	global	36	40	63	51

HEALTH INFORMATION MANAGEMENT AND DISSEMINATION

WHO objective(s)

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

Indicator(s) and achievement

A measurable increase in use of WHO information in all media. An increase in the use of WHO information in all media was documented, especially after the launch of top-level content on the WHO web site in the six official languages.

Application of best practices for storage, management and accessibility of health information. Improved application of best practices was achieved in the management and accessibility of health information to Member States and WHO staff at all levels. Additional achievements in eHealth in countries were also recorded in the context of a new knowledge management strategy.

Main achievements

- The Department of knowledge management was established in 2004. Coordination was improved during the biennium through a global leadership team process involving headquarters and regional focal points.
- A knowledge management strategy was issued in September 2005 after a year of planning, regional consultations and inputs from various stakeholders[1] to bridge the "know–do" gap in global health by improving access to health information; translating knowledge into policy and action; sharing and reapplying experiential knowledge; strengthening eHealth in countries; and fostering an enabling environment for knowledge management.
- Access to health information was improved through the expansion of the Health InterNetwork Access to Research Initiative to cover 105 countries and the endorsement of a Global Health Library by the Ninth World Congress on Health Information and Libraries (Salvador, Bahia, Brazil, 20-23 September 2005).
- Knowledge sharing was improved through online access for WHO staff at all levels to scientific literature and a knowledge management seminar series at headquarters. In the Region of the Americas, webcasting was conducted and OpenLink software used for the first time to share information on meetings, missions and consultations at all levels of the Organization.
- The launch of the Global Health Histories initiative in January 2005 was marked by a seminar with the participation of the former Director-General, Dr Halfdan Mahler.
- Strengthening of eHealth was achieved in countries through the establishment of the Global Observatory for eHealth, in line with resolution WHA58.28 and the subject of WHO's eHealth strategy was discussed at the World Summit on the Information Society (Tunis, 16-18 November 2005). A strategy for electronic health records for AIDS care was also developed.
- An information and communication technologies platform for health in Portuguese-speaking countries, produced in collaboration with the African Region and PAHO, and a Russian translation project in the European Region were launched. Thousands of existing multilingual publications and library services continue to be available.
- Several WHO flagship publications were produced including *The world health report*, the *Bulletin of the World Health Organization*, the *International statistical classification of diseases and related health problems*, tenth revision 2nd edition and *The European health report 2005*.[2]
- Knowledge translation was intensified during the biennium, for example, the replication in other regions of the Regional Office for Europe's Health Evidence Network, and a conference on knowledge translation in global health organized in Geneva. A registry and global network of public health partners was also initiated.

[1] Document WHO/EIP/KMS/2005.1.

[2] *The European health report 2005: public health action for healthier children and populations*. Regional Office for Europe, World Health Organization, Copenhagen, 2005.

Illustration of selected achievements

The eHealth unit has contributed to two knowledge management strategic objectives, namely, access to health information, and strengthening eHealth in countries. Notable among these achievements are the Global Observatory for eHealth, a network of national groups established in 2005 to analyse developments and trends in eHealth for the purpose of providing evidence and informing policy and practice. A first global eHealth survey generated data from more than 100 countries through close Organization-wide collaboration. The Health InterNetwork Access to Research Initiative continues to grow. One thousand eight hundred institutions in 105 countries have benefited from the programme, since December 2005, and users' downloads of full-text scientific articles almost doubled to 3 300 000 in 2005. Initial accomplishments of the network, established in 2005 to address the information needs of WHO's Portuguese-speaking Member States include the publication of *The world health report 2005* and complementary documents in Portuguese. Normative work on electronic health records for AIDS care was also carried out. The second phase of the World Summit on the Information Society (Tunis, 16-18 November 2005), saw greater involvement on the part of WHO. Successful sessions and informal consultations highlighted various eHealth initiatives; a special report entitled "Connecting for health: global vision, local insights" was issued jointly by WHO and the European Commission.

Achievement of Organization-wide expected results

Organization-wide health-information management strategies and policy in operation and periodically evaluated and updated

Indicator	Baseline	Target	Achievement
Number of information products compliant with organizational strategies and policies	352 848 copies of priced products distributed in 2002-2003 No Organization-wide policy framework available for publications	286 375 copies of priced products distributed in 2004-2005 New WHO publishing policies developed	The number of distributed copies declined as free web access increased. Existing WHO publishing strategies and policies reviewed; new WHO publishing policies developed. Regional publications compliant with regional offices policies (e.g. 200 in European Region)
Frequency of evaluation and updating of strategies and policy	None	Biennial	Revised policy on minimum criteria for WHO information products

During the biennium a review group for publishing policy was established with two representatives from each Region and all clusters at headquarters. The group has met four times and formed working groups on equitable dissemination, publishing policies, multilingualism, quality assurance and tracking. Draft policies on authorship and copyright and a revised policy on minimum criteria for health information have been developed. In addition, some regions have formulated specific policies on design, production, translation and dissemination of publications and the number of publications conforming to these policies is increasing.

Planning, production and dissemination of health information products in appropriate media (including print, web, multimedia and CD-ROM) and in appropriate languages (including all WHO official languages for selected high-priority globally-relevant products) improved through streamlined production/dissemination processes, policies and services

Indicator	Baseline	Target	Achievement
Availability of trend data on sales and distribution of health information products	US$ 5 582 000 in 2002-2003	US$ 6 350 000 in 2004-2005	14% revenue increase
Availability of statistics on access to WHO web sites	Web site hits not routinely monitored	Consistent tracking of web site use	Data on web site use collected continuously at headquarters and in regions

Indicator	Baseline	Target	Achievement
Proportion of global information products available in more than one language on the WHO web site	All products in top navigational layers of the WHO web site and news releases routinely published in English, French and Spanish	All products in top navigational layers of the WHO web site and news releases routinely published in all six official languages	Top navigational layers of the WHO web site, news releases and disease outbreak updates routinely published in all six official languages
Increased dissemination through content licensing	35 licensing and sales contracts	50 licensing and sales contracts	WHO has licensing and sales contracts with 5 major on-line booksellers and libraries, in addition to copyright and reproduction sales

The WHO Press was established through a reorganization of various publishing activities at headquarters. Several new initiatives have been launched and there has been an increase in sales revenue and the number of new dissemination channels. The WHO web site was relaunched in the six official languages and the volume of material in the new content management system has increased continuously. Most regional web sites have also been updated and new systems are in place for monitoring web use statistics both at headquarters and in some regions. In 2005, the WHO web site received more than 2.6 million visitors every month viewing, on average, 32 million pages. Multilingual web sites and postings continue to increase. To ensure multilingualism, translation contracts for books published in languages other than English have increased in number from 381 to 401 during this period.

Selected high-priority health information published, including *The world health report*, the *Bulletin of the World Health Organization*, WHO web site content and regional information products

Indicator	Baseline	Target	Achievement
Proportion of global WHO web content that follows guidelines for usability, accessibility and branding	120 sites maintained and published using the WHO web content management system	Increased number of sites that are managed and published through the WHO content management system	150 sites were maintained and published using the WHO content management system

Using the WHO content management system ensures that web content is published according to the latest industry standards for usability, accessibility and corporate branding. During the biennium, the *Bulletin of the World Health Organization* continued to be published monthly in both print and electronic formats and achieved high levels of citation and impact. *The world health report 2004: changing history* was devoted to HIV/AIDS; *The world health report 2005: make every mother and child count* shared the same theme as World Health Day and was published in all six official languages. Regional information products published during the biennium included periodicals, regional health reports and a variety of manuals, guidelines and training and advocacy material. These materials were also often translated into appropriate languages.

An evaluation framework for WHO's health-information products introduced, including: policies on best practice such as standards for scientific and editorial quality; regular assessments of target-audiences' needs; and assessment of the products with feedback on lessons learnt to the authoring units and executive management

Indicator	Baseline	Target	Achievement
Number of evaluated health-information products	Not established	Sample of health information products to be evaluated	Evaluation not carried out in headquarters due to changes in structure and budget of the department. Review planned as part of the work of the new review group for publishing policy. Regional offices conduct periodic reviews (e.g. all 10 high-priority corporate information products in European Region are evaluated at six-monthly intervals)

Indicator	Baseline	Target	Achievement
Number of case studies and reports on lessons learnt	Not established	Not established	Postponed due to reorganization of WHO Press
Number of plans for health-information products changed to fit the evaluation framework	Not established	Not established	Postponed due to reorganization of WHO Press

During the biennium, a number of training programmes were implemented aimed at improving the standard of writing, editing and proofreading in the Organization. Tools were also made available through the web site to assist both internal staff and freelance writers and editors to improve the scientific and editorial quality of WHO information products. The information production chain project was closed down because of delays and cost and simpler systems are being explored. At least one Regional Office has started a periodic evaluation of high-priority corporate information products and is receiving reports on the use of these products in countries.

WHO's health knowledge framework established, including: the identification and organization of essential knowledge assets (such as documents and structured data sets) and ensuring better access by all WHO staff to the information they need; information and communication technology support to communities of practice within WHO; promotion and facilitation of best practice in management of WHO health data (e.g. data storage, decision-support tool sets); and strengthening ability of countries to access, use, and contribute to the framework

Indicator	Baseline	Target	Achievement
Number of health knowledge assets identified and statistics on usage	Not established	Entire print collection in all WHO libraries Statistics collected on use of on-line and print materials	23 000 consultations of print periodicals; 12 000 book consultations; 40 000 full text WHO information items in WHO library database; 25 000 research requests and general requests; 750 000 downloads of online articles across WHO
Satisfaction of staff in different geographical locations with the information support needed for their work	Positive feedback but wanting more access to priced resources	10% increase in access to electronic resources	Subscriptions were based on expressed needs from staff. Electronic access of low-demand resources was phased out because of budget constraints
Number of supported communities of practice	Few spontaneous communities in WHO	Growth in number of communities	19 well characterized communities
Proportion of WHO health data sets that follow best-practice criteria in information management	Not established	Not established	Not systematically assessed

The comprehensive WHO library database provides full text online services such as access to the global information full text database and hard-copy collections, training, in-depth searching and information counselling, and a network of communities of practice inside WHO and globally. It is regarded as an authority and innovator within the United Nations system and international library community, and is widely used by WHO collaborating centres and in setting up new platforms for communities of practice fostering knowledge networks in support of health for all.

Success factors and impediments

Success factors

- Creativity and dedication of staff.
- Commitment to building a global team to lead the development and implementation of the knowledge management strategy.
- Efficient development of a strategy that is clearly understood by the Organization as a whole.
- Staff commitment and professionalism in delivering expected results despite the shortfall in human and financial resources.
- Ability to seek out and build alliances with others on the basis of shared interests.
- Ongoing support for core functions in publishing and library services despite budget constraints.

- The seeking out of new opportunities of broad interest and definition of WHO's role therein.
- Effective strengthening of technology.
- New focus of work at country level.

Impediments

- Inadequate communication of the knowledge management strategy at all levels of the Organization and to key partners and constituencies.
- Shortage of staff with the necessary skills to deliver the new strategy in a time of rapid change, although this will be addressed to some extent during the biennium 2006-2007.
- Difficulty in aligning common goals and approaches quickly across the regional offices and headquarters.
- Having to focus on too many different objectives with most resources still being directed towards internal service provision.
- The production of health information products is dependent on upstream planning processes. WHO Press needs better marketing intelligence on publishing trends, needs and impact.
- One Region lacks a dedicated budget, while in the others, knowledge management activities are spread across several departments.
- Lack of clear evidence regarding effective knowledge management practices for improving health outcomes in a systematic way.
- Knowledge management is still a new area and needs to build support in the public health community at large.
- Lack of clear knowledge management metrics in countries.

Lessons learnt in 2004-2005 and how they will be applied in 2006-2007

- It is important to heed countries' demands and to focus on matching evolving capacities to those demands in the coming biennium.
- The benefits of knowledge management need to be communicated more effectively. In 2006-2007 an inventory of relevant success stories in the health sector will be compiled and disseminated. Staff are being recruited to lead this effort.
- Staff are also being recruited to devise a knowledge management training programme and toolkit for both internal audiences and country-level health sector workers.
- The focus of the work is shifting to the country level. New resources must therefore be mobilized to strengthen health systems and improve health outcomes in countries.
- Countries need more effective assistance in knowledge management. Staff are being recruited to develop a model for providing effective technical assistance to priority countries in 2006-2007.
- It is essential to evaluate the need for and impact of WHO publications despite the difficulties involved. New approaches in this area should be given priority to maximize efficiency and assist target audiences.
- The drive towards modernization should continue. The dissemination of external information online has improved services to users regionally and globally. Better internal knowledge enterprise platforms will be developed in support of this work.
- There is a need to build regional ownership in the delivery of the knowledge management plan. Ways to encourage regional leadership of key events and projects, and to continue global collaboration and support in key initiatives will therefore be explored in 2006-2007.
- Measures are needed to assess the effectiveness of knowledge management tools, techniques and approaches in improving health outcomes. Some measures are proposed in the operational plan and in the appropriate country metrics.
- There is a need to build an evidence base for effective practices. Efforts will be made to work with the public health community in researching knowledge management in health policy and community enterprise.

Approved budget and actual expenditure

		Approved budget	Actual expenditure		
			Regular budget	Other sources	All funds
Total 2004-2005 (US$ thousand)		46 162	30 554	18 758	49 302
Percentage	countries	9	5	4	4
	regions	37	52	10	36
	global	54	43	86	60

RESEARCH POLICY AND PROMOTION

WHO objective(s)

To stimulate research for, with and by developing countries by identifying emerging trends in scientific knowledge with the potential to improve health; inciting the world research community to tackle high-priority health problems; and launching initiatives to strengthen research capability in developing countries so that health policy will be founded on solid evidence from research.

Indicator(s) and achievement

Strong health research systems in countries. Health research systems were strengthened in 13 low- and middle-income countries through their involvement in the health research systems analysis initiative, whose aim is to strengthen national health research capacity and health research systems in Member States, in particular, developing countries.

Increased global emphasis on research into health problems of developing countries. There has been increased emphasis on research into the health problems of developing countries. The Ministerial Summit on Health Research, held in Mexico City in November 2004, focused on the research needed to achieve the health-related Millennium Development Goals. It was also the first time health ministers had discussed health research.

Main achievements

- There was more frequent collaboration with regional offices during the biennium, for example, they were involved in the organization of preparatory meetings for the Ministerial Summit on Health Research and in the health research systems analysis initiative.
- Following the Ministerial Summit, an evidence-informed policy network to bridge the gap between research policies and practices in the health sector was launched in the Western Pacific Region and will be introduced in the African Region in 2006.
- Since the Ministerial Summit, the visibility of health research at meetings of WHO's governing bodies has improved. The report launched at the Summit has also raised awareness of health research and WHO's role and responsibilities in it.[1]
- WHO was able to provide support to countries and the international community through the evidence-informed policy network, the health research systems analysis initiative and the international clinical trials registry platform.

Illustration of selected achievements

- The Fifty-eighth World Health Assembly adopted resolution WHA58.34 acknowledging the outcome of the Ministerial Summit on Health Research, held in Mexico City in November 2004.[2] Among the 400 participants at the Summit were 21 health ministers, three deputy ministers and 28 heads of delegations, in marked contrast to the International Conference on Health Research for Development, held in 2000, where only one health minister was present. The main aim of the next International Conference will be to persuade health ministers to participate to ensure that its outcomes are endorsed by all Member States.

[1] *World report on knowledge for better health: strengthening health systems.* Geneva, World Health Organization, 2004.

[2] Resolution WHA58.34.

Achievement of Organization-wide expected results

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

Indicator	Baseline	Target	Achievement
Degree to which current trends, advances in knowledge and good ethical standards are reflected in WHO's research-policy positions.	Trends, advances and ethical standards not systematically reflected in WHO's research policy positions	Evidence of reflection of trends, advances and standards in WHO research policy positions	The position paper on WHO's role and responsibilities in health research, discussed by Executive Board in January 2006, is expected to lead to changes in research policy within WHO
Presence and prominence of WHO research policy in the global health research agenda	Limited presence and prominence	Positioning of WHO research policy at centre of global agenda	Evidence of enhanced presence and prominence at the Ministerial Summit on Health Research and through publication of report[1]

WHO's current and future roles and responsibilities in health research both inside and outside the Organization are clarified in the position paper.

Mechanisms in operation for setting up networks and partnerships to improve international cooperation for health research, including practical and sustainable links between the global and regional Advisory Committee on Health Research

Indicator	Baseline	Target	Achievement
Number of regional Advisory Committees on Health Research with explicit operational and procedural links to the global Advisory Committee on Health Research	6	6	6
Number of partnerships and networks set up to improve international cooperation between WHO and other organizations involved in health research	3	5	5

All chairmen of regional advisory committees on health research are now full members of the Advisory Committee on Health Research. In addition to launching the evidence-informed policy network and the international clinical trials registry platform in 2005, WHO has continued to cooperate and liaise with the Global Forum for Health Research and the Council on Health Research for Development. The Alliance for Health Policy and Systems Research became part of WHO as their work became increasingly interconnected. The Regional Office for the Western Pacific has fostered long-term partnerships with the Forum for Ethical Review Committees in the Western Pacific Region, and the Heath Research Council of New Zealand has collaborated with the Alliance for Health Policy and Systems Research and Canadian partners in the preparation of the evidence-informed policy network. It also has an ad hoc collaboration arrangement with the Council on Heath Research for Development and the Pacific Health Research Council.

[1] *World report on knowledge for better health: strengthening health systems.* Geneva, World Health Organization, 2004.

Framework in operation for providing policy and technical support in order to strengthen health research and capability for such research in developing countries, including methods and strategies to assess performance of health research systems

Indicator	Baseline	Target	Achievement
Number of regional offices, country offices and WHO collaborating centres with real-time web access to the major global databases of scientific and policy information relevant to health research and other databases related to WHO research activities, expert advisory panels and WHO collaborating centres	Not established	Not established	Data not available
Analytical work and methods relating to performance assessment of health research systems	10	15 countries were originally invited to become part of the health research systems analysis pilot project	13 low- and middle-income countries were involved in the pilot project
Number of initiatives to strengthen health research capacity in selected areas	3	5	5

Pilot studies on health systems research in thirteen countries are almost complete. Tools and methodologies for health systems research have been made available to countries for local adaptation. The evidence-informed policy network has been established in five countries in the Western Pacific Region and will be extended to the African Region in 2006. The Regional Office for the Western Pacific has also been involved in research related to noncommunicable diseases, including STEPwise approach to surveillance surveys and a new small grants research programme under the auspices of the Special Programme for Research and Training in Tropical Diseases.

Support and advice provided within WHO on research-related activities

Indicator	Baseline	Target	Achievement
Evidence of the importance given to health research issues in WHO reports, documentation and press releases	Insufficient importance accorded to health research in WHO	More importance accorded to health research in WHO	Position paper on WHO's role and responsibilities in health research discussed by Executive Board in January 2006 Ministerial Summit on Health Research mentioned in the reports of 8 other departments in headquarters. In the regions, research supported activities through regional advisory committees on health research and regional counterparts of 4 departments

The Fifty-eighth World Health Assembly adopted resolution WHA58.34, requesting the Director-General to undertake an assessment of WHO's internal resources, expertise, and activities in the area of health research, with a view to developing a position paper on WHO's role and responsibilities in the area, and to report through the Executive Board to the Fifty-ninth World Health Assembly.[1]

[1] Resolution WHA58.34.

Mechanisms in place for increasing capability of WHO collaborating centres to engage in research in high-priority areas

Indicator	Baseline	Target	Achievement
Greater activity of WHO collaborating centres in high-priority areas of research as parts of national or regional networks of centres	Not established	Not established	During the biennium the collaborating centres were streamlined and the number of inactive centres was dramatically reduced
Level of technical support and support for resource mobilization provided to WHO collaborating centres for research-related activities in high-priority areas	Not established	Not established	Little progress because of financial constraints

The Regional Office for the Western Pacific supported the establishment of a network of collaborating centres and centres of expertise in Thailand. A network secretariat was formed and a monthly newsletter is being distributed in Thailand and to other Member States.

Support and advice provided to Member States, and within WHO, on matters pertaining to ethics and health

Indicator	Baseline	Target	Achievement
Number of Member States and WHO programmes receiving advice on matters pertaining to ethics and health	Not established	Not established	In 2004-2005, 359 proposals from 75 Member States in 2004 and 53 in 2005 were reviewed In 2004-2005, the Ethics Research Review Committee considered 357 proposals from WHO departments

The staff representative on the Research Ethics Review Committee was a member of the selection committee on proposals for funding from the Regional Office for the Eastern Mediterranean in the form of a special grant for research in priority areas of public health. A satellite meeting of the Global forum on bioethics in health research held in Blantyre, Malawi in March 2005, was organized for the African Region. The Regional Office for the Western Pacific sponsored participants from about 10 countries to attend training sessions in research ethics or conferences such as the annual Conference of the Forum for Ethical Review Committees in the Western Pacific Region, held in Pattaya, Thailand in December 2005.

Success factors and impediments

Success factors

- An institutional culture that is appreciative of sound research
- Improved visibility of research initiatives in WHO

Impediments

- The availability of limited financial and human resources, which has restricted the response to the expectations emanating from the Ministerial Summit on Health Research.
- Conflicting responsibilities of staff in some regional offices limit the time available for health research activities.
- A lack of political will and commitment to health research: the Ministerial Summit on Health Research was the first occasion on which health ministers had discussed the subject.
- Delays in establishing an effective international clinical trials registry platform as a result of the vested interests of pharmaceutical companies.

Lessons learnt in 2004-2005 and how they will be applied in 2006-2007

- Better planning is required for major initiatives. Consequently, preparatory meetings for the Ministerial Summit in 2008 have already been held.

- In 2006-2007 requests for funding will take account of donor priorities, agendas and activities.
- Joint planning with regional offices for health research must take account of different priorities and varying levels of awareness and capacity in the regions.

Approved budget and actual expenditure

		Approved budget	Actual expenditure		
			Regular budget	Other sources	All funds
Total 2004-2005 (US$ thousand)		20 217	8 024	5 919	13 943
Percentage	countries	37	15	1	9
	regions	23	42	42	42
	global	40	43	57	49

ORGANIZATION OF HEALTH SERVICES

WHO objective(s)

To work with Member States to improve their capacity to deliver high-quality health services affordably, efficiently and equitably to all their populations, especially the poorest and most vulnerable, by developing and enhancing systems for planning and delivery of health services and to gather evidence and design tools that support informed and participatory framing and implementation of policy.

Indicator(s) and achievement

Availability of practical tools to help policy-makers and health professionals to analyse the impact of health systems on access and health outcomes of the poor, and to improve the quality and performance of health services. Guidelines were prepared on the following aspects of human resources for health development: in post-conflict situations, rapid assessment, policy and planning, essential public health functions, national health accounts, and health sector analysis.

Strengthened ability of countries to adapt and use these tools in their own settings. Forty-six countries improved their capacity to implement tools and guidelines through: regional training workshops, national events, pilot studies and the formation of technical working groups.

Functioning networks with regional and national institutions and active partnerships with other international agencies supporting the development of more effective stewardship, financing, and generation and provision of resources in countries. Partnerships were strengthened and regional networks either established or strengthened in all regions.

Main achievements

- The recent attention paid to the health workforce by the High-Level Forums on the Health MDGs, the Oslo consultation, the Joint Learning Initiative, and the African regional consultation has contributed to the development of common strategies for a more concerted effort by key partners. A transitional working group has been working to better define a global health workforce alliance to enhance the effectiveness of country strategies in strengthening the health workforce. Many activities have been triggered by *The world health report 2006* and World Health Day 2006, both of which are dedicated to human resources for health.
- WHO launched the World Alliance for Patient Safety, to stimulate awareness and political commitment to improving patient safety in all Member States by building on existing national efforts and initiatives. It is expected to significantly improve safety in the long term and lead to a decrease in both adverse effects and expenditure.
- The Commission on Social Determinants of Health, composed of 20 commissioners from government, civil society and academia representing all the regions was set up to promote policy changes and action on the social determinants of health.

Illustration of selected achievements

The High-Level Forums held in Abuja in 2004 and Paris in 2005, and a consultation held in Oslo in 2005 helped make human resources for health development a top priority. *The world health report 2006* triggered improvements in data collection and verification in all regions, studies on the regulation and accreditation of health workers in the South-East Asia and Eastern Mediterranean Regions and on the migration of health personnel in the Western Pacific Region, and high-level policy dialogues in the European Region. The stakeholders' consultation at the Regional Office for Africa in July 2005 prepared the way for implementation of the human resources for health agenda agreed in Abuja, Paris and Oslo. The situational analysis and review undertaken at country- and regional-levels in the Western Pacific Region led to the development of a draft regional strategy for 2006-2015. A draft Pacific code of practice for the recruitment of health personnel in the Pacific island countries is also being drawn up. A comprehensive mapping of human resources for health development was carried out in 14 Member States in the Eastern Mediterranean Region. In the South-East Asia Region, the focus was on strengthening public health institutions. In the European Region, the application in 2004 of the findings of a study raised migration policy issues and a policy dialogue on the subject was organized for the Baltic countries in 2005. In the Region of the Americas, human resources observatories are functioning and efforts continue to establish similar bodies in the African Region.

Achievement of Organization-wide expected results

Frameworks validated for use by countries to gather and analyse changes in health system organization and their effects on access to services and health outcomes of the poor

Indicator	Baseline	Target	Achievement
Availability of practical tools (such as national health accounts) to help policy-makers to analyse health system changes and their effects on access and health outcomes of the poor	None in developing countries	Tools developed and tested in targeted countries	Several tools were developed, including guidelines on human resources for health in post-conflict situations

Several mechanisms and indicators to improve health service delivery and outcomes were designed and implemented in some Member States, namely, country profile indicators; the health-sector analysis tool; national health accounts; and an essential public health functions tool in the Region of the Americas. In the European Region, national health accounts adapted to countries' needs are being prepared and/or implemented in three Member States, and quality assessment, performance measurement, accreditation and licensing tools were either devised or are in the process of development.

Strategies formulated to strengthen national capacity for framing and implementing policies to improve health of the poor, focusing on high-priority health conditions and better stewardship (including legislation and regulation and accreditation)

Indicator	Baseline	Target	Achievement
Strengthened national capability to formulate and implement policies to improve health of the poor in selected countries in all WHO regions	Limited capacity	Improved capacity, including tools and policy documents developed	Social exclusion tool was designed and implemented in 9 countries

In the European Region, health policy documents were prepared or updated in four Member States; specific health and poverty documents were produced in two Member States; and a satisfactory level of implementation or introductory work was achieved in 10 Member States.

Knowledge bases, networks and partnerships maintained and extended in order to build capacity in countries to support improved health system stewardship, financing, and generation and provision of resources in countries, and the strengthening of management processes at national and subnational levels

Indicator	Baseline	Target	Achievement
Functioning networks of regional and national institutions and active partnerships with other international agencies, supporting the development of more effective stewardship, financing, and generation and provision of resources in countries	Nascent networks in some regions	Developed and strengthened networks in all regions	Regional networks have been established or strengthened in all regions
Publicly accessible information bases on organization of health systems' functions	Gaps in availability and use of information basis	Improvement in availability and use of information resources on health systems	Country health systems profiles available for most countries in the European and Eastern Mediterranean Regions. A special web site for health service managers that focuses on those with limited resources was launched at headquarters

At global level, a network of experts and practitioners in health workforce development includes more than 600 subscribers. The network, which is moderated by WHO is a collaborative venture. An alliance on human resources for health was established in 2006. At regional level, the Observatory of Human Resources for Health in the Region of the Americas continued its work. In the South-East Asia Region, functional networks were established for public health and medical education. In the European Region, the health promoting hospitals project was initiated, partnerships with the Council of Europe, the European Commission, the World Bank and the United States Agency for International Development were strengthened, and a joint flagship course on health-sector reform and sustainable financing was organized with the World Bank. In the Western Pacific Region, an e-learning initiative, the Pacific open learning health network, was created by the Regional Office and its partners to

support access to information and the training of health workers in small island countries. In the Eastern Mediterranean Region, the Regional Observatory on Health Systems produced health system profiles for 18 Member States using a standard template. Other examples of publicly accessible information are the global atlas of the health workforce and the national health account database at headquarters, a clearinghouse on health-sector reform in the Region of the Americas, and a publication on health systems in transition for Member States in the European Region.[1]

Evidence and best practices validated and countries supported to define and implement their policy options on health service provision and the development and use of human resources (including motivation and migration issues)

Indicator	Baseline	Target	Achievement
Availability and implementation of policy options to improve health service coverage and the recruitment and use of human resources, based on validated evidence and best practices, in selected countries in all WHO regions	6 countries carried out an in-depth analysis of human resources for health; 4 countries have developed national plans	20 countries using policy options and tools	26 countries developed and implemented policy options on human resources for health, including retention and migration of health workers

Sixteen Pacific island countries developed a draft code of practice for the recruitment of health personnel. Fourteen Member States in the Eastern Mediterranean Region are using WHO policy options and tools on human resources development. In the African Region 12 countries prepared health workforce policies and plans and four countries applied staff retention strategies.

Strategies, methods, guidelines and tools devised in order to enable countries to assess coverage and provider performance and to improve the delivery and quality of health services to individuals and populations

Indicator	Baseline	Target	Achievement
Availability of strategies, methods and tools and ability to apply them in selected countries for assessing coverage and provider performance, and improving the delivery and quality of health services	6 countries using the Essential Health Technology Package for resource allocation and improvement of service delivery	10 countries using the Essential Health Technology Package	10 countries using the Essential Health Technology Package for resource allocation and improvement of service delivery, especially for Making Pregnancy Safer
Evidence of application of tools at subnational level in selected countries in all WHO regions	Use or application of tools uncertain	Use of tools in 25 countries	Tools on quality assurance programs and hospital quality and performance assessment used in 21 countries. A framework for assessing management development approaches in low-income countries was applied in 3 African countries in 2005

In preparation for the Montreux Challenge: Making Health Systems Work, held in Glion sur Montreux, Switzerland in April 2005, technical frameworks were drawn up for health financing, the health workforce, health information systems, local management, and the role of the non-state sector in attaining the Millennium Development Goals in low-income countries. Ways in which global health initiatives can contribute to strengthening specific components of health systems and possible pitfalls were articulated. Fifteen Member States in the Eastern Mediterranean Region applied national quality assurance programmes. In the European Region, tools for assessing the quality and performance of hospitals were piloted in 40 hospitals in six Member States. At country level, Bangladesh revised and re-introduced a planning tool-kit for use at local level**.** Additional tools and guidelines are being prepared in all regions. In the European Region, the updating of 29 country health needs assessments produced recommendations on coverage and human resources; the regional strategy on the renewal of primary health care was also continued through national and regional consultations.

[1] *Health systems in transition: learning from experience*. Copenhagen, World Health Organization, 2004.

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

Indicator	Baseline	Target	Achievement
Methods and tools for improving the distribution, quality and performance of health workforce available and used in targeted countries in all WHO regions	0	10 countries testing special tools	Tools were developed and tested in 9 countries

Several tools for health workforce applications were used in five Member States in the Western Pacific Region: an estimates/projections model, staff performance assessment tools and workload indicators for staffing needs. In the European Region, education and accreditation tools are being prepared with partners such as the World Federation for Medical Education and studies linked to *The world health report 2006* were carried out.

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

Indicator	Baseline	Target	Achievement
Improvement in mechanisms, methods and capacity, in support of countries' requests for advice on policy and system improvement, compared with baseline established in 2002-2003	Unsystematic approach to country support	Improved mechanisms for country support	Improvements include a more systematic approach to country support in decentralization, health-care financing and scaling-up human resources

A rapid assessment of the managerial capacities for health service delivery at district level was conducted with headquarters in South Africa, Togo and Uganda. The lessons learnt will generate national and intercountry debates and be reflected in *The world health report 2006*. In the European Region, five policy dialogues and two high-level international workshops were organized. In the Western Pacific Region, support to improve health-sector decentralization was provided to Indonesia, regional- and country-level capability to advise on macroeconomics and health was strengthened, and health-care financing workshops were held. At headquarters, technical advice on aspects of human resource development was provided to priority health programmes such as Stop TB, HIV/AIDS and malaria. In addition, a publication was produced containing general guidance for policy-makers, health care managers, administrators and health-care providers for the rapid scaling-up of health services using HIV/AIDS treatment and care as examples.

Strategies, guidelines, tools and partnerships developed to strengthen WHO and countries' capabilities to articulate and implement equitable health policies in support of national poverty-reduction strategies and the Millennium Development Goals

Indicator	Baseline	Target	Achievement
Strengthened institutional capacity in WHO and poverty-reduction strategy countries for the formulation of pro-poor health policies and interventions in the context of national poverty-reduction programmes	Limited knowledge in WHO and Member States of pro-poor policies	Enhanced knowledge on Millennium Development Goals and Poverty Reduction Strategy Papers	Reports on the Millennium Development Goals and analysis of Poverty Reduction Strategy Papers were published by headquarters and the WHO Regional Offices for the Americas, Europe and the Western Pacific

A report on the Millennium Development Goals was prepared for submission to the Fifty-fifth session of the WHO Regional Committee for Europe and a taskforce on the Millennium Development Goals was also established. Tools for the integration of poverty and gender into health professional training and education were produced in the Western Pacific Region. In Bangladesh, primary and secondary level health personnel were trained on pro-poor service delivery. In the Region of the Americas, training on sector-wide approaches was provided in seven Member States.

Strategies, methods, guidelines and tools devised, in order to enable countries to establish and strengthen evidence-based policies and systems necessary for improving patients' safety as a fundamental component of quality of health care

Indicator	Baseline	Target	Achievement
Availability of strategies, methods, guidelines and tools, capacity to apply them and evidence of their use in 40 countries, for establishing and strengthening evidence-based policies and systems necessary for improving patients' safety	0 countries	40 countries with available strategies, methods and tools for patient safety	46 countries with improved capacity to implement tools and guidelines through: regional training workshops, national events, capacity building, pilot studies and technical working groups
Availability of a policy framework and mechanisms that promote a culture of safety and support systemic changes towards improved patient safety	Discussions on mechanisms to support patient safety efforts started	To roll-out activities on patient safety in all regions	Regional patient safety workshops and events for countries conducted in 5 regions covering over 100 countries. Work initiated in all 6 patient safety action areas of the forward programme of the World Alliance for Patient Safety

The World Alliance for Patient Safety was established and launched in October 2004 as a vehicle for international collaboration and action on patient safety. Tools and guidelines for hand hygiene, reporting and learning, and patient safety research were produced. In the Eastern Mediterranean Region, studies and surveys were conducted and guidelines prepared on referral services in five Member States, and on emergency medical services in 14 Member States. In the European Region, a document on health systems was produced for the Fifty-fifth session of the WHO Regional Committee for Europe. In the Region of the Americas, a regional network to prepare guidelines on clinical practices was established and three Member States developed research projects on the quality of patient care and safety.

Success factors and impediments

Success factors

- Renewed interest in strengthening health systems and recognition of the need for more concerted action, as well as the expectation that WHO will provide the necessary leadership.
- Strengthened global and regional partnerships and greater commitment to health systems and human resources for health, especially in Africa.
- The increase in funds available at country level through international funding mechanisms and need for coordinated approaches.
- Strong demand from Member States for support to improve or upgrade their health services and systems.

Impediments

- Limited financial and human resources for responding to increased demands.
- The structure of the General Programme of Work and related reporting obligations hamper coordination and teamwork at global level.
- A lack of commitment by key partners or competing commitments of national counterparts.
- Bias in allocation of major funding in priority areas is not conducive to more sustainable health-systems improvements.

Lessons learnt in 2004-2005 and how they will be applied in 2006-2007

- Increased exposure of country health-system staff to other countries builds knowledge and expertise and fosters capacity and confidence building. The practice should be encouraged in the next biennium.
- Building partnerships and consensus to strengthen health systems requires a more concerted approach and sustained commitment by all levels of WHO, as well as its partners.
- The need for a coordinated long-term approach to human resources and health systems should be partly met by the draft regional human resources strategy for 2006-2015 and the health system strengthening strategy being prepared by the Regional Office for the Western Pacific and headquarters, respectively.

Approved budget and actual expenditure

		Approved budget	Actual expenditure		
			Regular budget	Other sources	All funds
Total 2004-2005 (US$ thousand)		159 966	101 440	44 494	145 935
Percentage	countries	61	65	39	57
	regions	22	25	24	25
	global	17	10	37	18

GOVERNING BODIES

WHO objective(s)

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

Indicator(s) and achievement

Greater consensus in Health Assembly deliberations. During 2004-2005 the level of consensus reached in negotiations on resolutions was considerably greater than in previous years, as evidenced, for example, by the agreement for a regular budget increase for the first time in 10 years.

Main achievements

- During the biennium, each of the regional committees met twice, generally with one or more standing committees or subcommittees carrying out the preparatory work.
- Meetings of the governing bodies were held as planned, as per the requirements of accessibility, readability and recognized quality referred to in the WHO objective.
- The Programme, Budget and Administration Committee of the Executive Board was established, replacing three committees – the Programme Development Committee, the Administration, Budget and Finance Committee, and the Audit Committee.
- The International Health Regulations (2005) were adopted.
- Work of the Open-ended Intergovernmental Working Group on the WHO Framework Convention on Tobacco Control was completed in preparation for the first Conference of the Parties.
- Meetings were held in the appropriate official languages and documentation was provided in the languages prescribed by the rules of procedure of each governing body, or the parent governing body in the case of subsidiary committees.
- Regions reported that the holding of regional governing body meetings had proceeded well, with appropriate and practical outcomes reflecting increased cooperation, communications and policy coordination between Member States and the Secretariat, and, in some cases, improved documentation.

Illustration of selected achievements

Despite connectivity constraints in some areas and the requirement to provide documents to more than 40 countries, for the first time in the African Region all relevant documentation was posted on the Internet before the fifty-fifth session of the Regional Committee and the regional report was posted within four weeks of the conclusion of that meeting. All participating countries and organizations also received copies of all the relevant documentation on CD-ROM.

Achievement of Organization-wide expected results

Resolutions adopted that focus on policy and strategy and provide clear directions to Member States and WHO's Secretariat on their implementation

Indicator	Baseline	Target	Achievement
Proportion of resolutions adopted that focus on policy and can be implemented at global, regional and national levels	No direct correlation of resolutions with programme budget	Increased number of resolutions in accordance with agreed programme budget	For the 117th session of the Executive Board, all resolutions (100%) prepared by the Secretariat were costed and related to Programme budget 2006-2007

Strong emphasis was placed on realistic requirements for reporting on the implementation of resolutions by Member States and the Secretariat. During the biennium, 25 out of 33 technical resolutions had a reporting framework that could be described as realistic (over two or more years). In accordance with Financial Regulation XV, preparation began in 2005 for all resolutions proposed to the Executive Board to be accompanied by a statement of resource implications. The approach of costing and relating all resolutions to the programme budget will be further developed during 2006.

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

Indicator	Baseline	Target	Achievement
Frequency of effective use of communication channels between Member States and governing bodies at global, regional and country levels, concerning the work of WHO	Mission briefings, Virtual Executive Board, web site, electronic consultation	Additional mechanism	Bimonthly Executive Board newsletter established in July 2005

In 2004, more than 6.5 million pages were downloaded from the governing bodies' subsites of the WHO web site; in 2005, the corresponding figure was 10.0 million, making the governing bodies' web pages the eighth-most-visited pages of all the subsites on WHO's web site. In 2005, breakdown by language shows that about 24% of the documents downloaded were in English and between 13% and 18% each in Arabic, Chinese, French, Russian and Spanish. In 2004, the Virtual Executive Board was upgraded into a web site functioning in all six official languages and, in 2005, it was used to host consultations on the Millennium Development Goals and health research.

Governing body meetings held in all the official languages of WHO at global level and in agreed official languages for the regional committees

Indicator	Baseline	Target	Achievement
Proportion of governing body meetings held in appropriate official languages	100%	100%	100%

All documentation for the Health Assembly, Executive Board, regional committees and other intergovernmental meetings was translated into appropriate languages; however, there were several instances of lengthy background documents not being made available in all six languages for the Executive Board or Health Assembly, and of lengthy documents not being produced in a timely manner. Regions did not report any occurrences of this problem.

Communication and coordination in establishing the work programmes of regional and global governing bodies improved

Indicator	Baseline	Target	Achievement
Degree of congruence of agendas and resolutions of the regional and global governing bodies	Little organizational coordination	Increased explicit coordination	Evidence of increased coordination between regional and global bodies

In 2005, two regional committees explicitly requested the Director-General to place items on the agenda of the Executive Board. During 2004, all regional committees reviewed the Programme budget 2006-2007. In 2005, the General Programme of Work, strategic resource allocation and the medium-term strategic plan were reviewed.

Success factors and impediments

Success factors

- Improved coordination with Member States at regional and headquarters levels.

Impediments

- At headquarters, the volume of documentation required for meetings that are often held almost back-to-back. The fact that the "four-page principle" is often not appropriate or observed further aggravates the impact of this constraint.
- Financial and human resources are inadequate to overcome the aforementioned problem.
- One regional office reported that distance is a factor impeding the timely delivery of documents.

Lessons learnt in 2004-2005 and how they will be applied in 2006-2007

- In-depth and extensive consultation with Member States is very important for the preparation of meetings and will be broadened, to the extent possible, in 2006-2007.

- Concise and well-prepared documentation is of benefit to both Member States and the Secretariat. Adequate human resources must therefore be ensured in 2006-2007 to prepare documentation, especially given increasing demands for document production.
- Most governing body meetings are constrained by an overloaded agenda. In 2006-2007 the process for selection of the agenda will need to be more disciplined.

Approved budget and actual expenditure

		Approved budget	Actual expenditure		
			Regular budget	Other sources	All funds
Total 2004-2005 (US$ thousand)		27 791	23 794	4 568	28 362
Percentage	countries	0	0	0	0
	regions	12	17	11	16
	global	88	83	89	84

RESOURCE MOBILIZATION, AND EXTERNAL COOPERATION AND PARTNERSHIPS

WHO objective(s)

To negotiate, sustain and expand partnerships for health globally; to strengthen WHO's collaboration with intergovernmental and governmental bodies, civil society organizations, the private sector and foundations; and to secure the Organization's resource base.

Indicator(s) and achievement

Number of functioning partnerships established with bodies of the United Nations system, the private sector and civil society. At least 300 partnerships have been formed with United Nations agencies, the private sector and civil society.

Main achievements

- Effective consultations and coordination took place within the United Nations system and with intergovernmental organizations.
- Networks were built within the WHO Secretariat to enhance coherence in the work carried out with external partners in health.
- The prominence of health development increased in international forums such as the United Nations General Assembly, the G8 group of countries, the European Union, the World Economic Forum, and the United Nations Economic and Social Commission for Asia and the Pacific.
- The international community was effectively mobilized to take action on global health issues such as tobacco, avian influenza, the International Health Regulations (2005), health research, mental and environmental health and immunization.
- The involvement of the private sector in addressing and finding solutions to public health issues increased during the biennium.
- There was an improvement in the alignment of country-level activities through the United Nations Resident Coordinator system and WHO's active participation in priority humanitarian and development issues.
- New strategic collaboration was achieved with the European Commission, ASEAN, the International Federation of Red Cross and Red Crescent Societies, the Organization of the Islamic Conference, and United Nations Volunteers, among others.
- Several important new partnerships and alliances were initiated, for example in health metrics, newborn, maternal and child health, household water treatment and safe storage, chronic diseases and violence prevention.
- A total of 184 nongovernmental organizations are now in official relations with WHO.

Illustration of selected achievements

In 2004-2005 voluntary contributions increased by about 30% over 2002-2003 levels. Improved distribution of resources across areas of work and offices was also recorded. Available resources exceeded approved programme budget requirements for 22 areas of work and all were at least 70% funded. This is a significant improvement over the previous biennium and demonstrates progress in ensuring proper alignment between contributions and the institutional priorities identified in the programme budget.

Achievement of Organization-wide expected results

Sustained and expanded partnerships for health globally; strengthened collaboration with intergovernmental and governmental bodies, civil society organizations, the private sector and foundations; and secured resource base for WHO

Indicator	Baseline	Target	Achievement
Number of consultation and briefing sessions with WHO's sister agencies, other organizations and interested parties in the health sector	Annual policy consultations; regular technical interaction	Annual policy consultations; regular technical interaction	Significant increase due to growth in number of partnerships
Number of policy areas where there is congruence with other stakeholders	27 areas of work define WHO's technical	Collaboration with partners based on areas of work	Increasing alignment with areas of work, but partnerships are often still based on specific health interventions

Indicator	Baseline	Target	Achievement
	programme, yet collaboration often not based on these		

The growth of global health partnerships such as the Global Fund to Fight Aids, Tuberculosis and Malaria and the Global Alliance for Vaccines and Immunization has demonstrated the importance of WHO's strategic and technical guidance, both at global- and country-level, and the need for WHO's systematic involvement in advisory and delivery mechanisms.

Effective mechanism for coordination of input to and feedback from important international forums, including major United Nations conferences and summits

Indicator	Baseline	Target	Achievement
Final declarations and plans of actions of global, regional and national conferences, and development agendas that reflect WHO's health goals and priorities	Health interests not adequately reflected in international forums for development and humanitarian assistance	Systematic incorporation of health development in the context of achievement of the Millennium Development Goals in international events addressing Member States' needs and WHO goals and priorities	Active WHO participation in United Nations and other international development forums to promote health as a key determinant for development, social well being and achievement of the Millennium Development Goals. In resolution WHA58.25, the Secretariat is requested to adhere to the international harmonization and alignment agenda and to coordinate with other United Nations organizations. Health issues were effectively included in regional strategies such as the New Partnership for Africa's Development

WHO co-organized two high-level forums on achievement of the health Millennium Development Goals in Abuja, in December 2004 and in Paris in November 2005, at which strategies were devised for guidance on sector-wide approaches in country development mechanisms for the United Nations system. The Regional Office for Africa has carried out cross-Organizational planning to increase access to essential public health interventions. Country cooperation strategies are being applied consistently in line with the harmonization agenda drawn up at the high-level forum in Paris to reinforce country ownership, capacity building and use of country systems for the implementation of health cooperation programmes. WHO was invited to act as a coordinator on road safety issues within the United Nations system. Five resolutions adopted by the United Nations General Assembly at its fifty-ninth session are of particular relevance to WHO ("Decade to Roll Back Malaria in Developing Countries, Particularly in Africa" – resolution 59/256; "Enhancing capacity-building in global public health" – resolution 59/27; "Triennial comprehensive policy review of operational activities for development of the United Nations system" – resolution 59/250, concerning harmonization and the Resident Coordinator system; "Strengthening emergency relief, rehabilitation, reconstruction, and prevention in the aftermath of the Indian Ocean tsunami disaster" – resolution 59/279; and the "United Nations Declaration on Human Cloning" – resolution 59/280).

In line with the aims set out at the high-level forums on achievement of the health-related Millennium Development Goals, the Regional Office for Africa is collaborating closely with the African Union through the New Partnership for Africa's Development to implement the latter's health strategy; the WHO Regional Office for the Americas is collaborating with the Economic Commission for Latin America and the Caribbean in the preparation of a special report for the region; the Regional Office for the Eastern Mediterranean is collaborating with United Nations agencies to ensure health reporting coverage in all its Member States; and the Regional Office for the Western Pacific is collaborating with the Asian Development Bank on achievement of the Millennium Development Goals. The regional offices for South-East Asia and Europe cooperated in their response to the Indian Ocean earthquakes and tsunamis. Cooperation arrangements were made with the International Federation of Red Cross and Red Crescent Societies and United Nations Volunteers to enhance health action on the ground.

Dynamic and coordinated fundraising under way with current and potential donors, focused on the integrated resource base of the programme budget and unspecified funding by area of work

Indicator	Baseline	Target	Achievement
Level of extrabudgetary resources	Carry-over in technical programmes of US$ 500 million	Voluntary contributions of US$ 1.4 million	Voluntary contributions of US$ 1.9 million received

Indicator	Baseline	Target	Achievement
Extent of increase in unspecified funding support to WHO	19.6% of voluntary contributions received in 2002-2003 recorded as unspecified	Not established	20.4% of voluntary contributions received in 2004-2005 recorded as unspecified (8% increase)

WHO's fundraising in 2004-2005 raised sufficient resources to meet the programme budget target. A significant improvement in resource coordination led to a better alignment across areas of work than that seen in the biennium 2002-2003; as a result, resources were more closely aligned with approved programme budget priorities. Although there was only an 8% increase in unspecified contributions, the fact that total voluntary contributions received in 2004-2005 amounted to approximately US$ 600 million more than in 2002-2003 meant that the actual amount of unspecified funding was considerably greater. Although almost half the resources were mobilized for efforts concerning poliomyelitis and emergency response, the Organization raised slightly more than 100% of the income target for all the other areas of work combined.

New partners mobilized for WHO, notably through global alliances and improved interaction with the private sector

Guidelines on interaction with commercial enterprises drawn up and applied

Staff awareness raised of issues related to collaboration with private sector, including conflict of interest

Indicator	Baseline	Target	Achievement
Number of private-sector partners working with WHO to achieve public health outcomes	74	100	114
Number of orientation and training sessions on management of conflict of interest	0	1	2

The biennium was marked by the noticeable progress made in applying a coherent approach to collaboration with the private sector and in the selection of suitable partners for the attainment of WHO's objectives. Better staff awareness of the methodology for involving the private sector in achieving global public health goals translated into effective cooperation with the pharmaceutical, health insurance, transport, sanitation, information technology and chemical sectors.

Policies and strategies for WHO interaction with civil society organizations revised

Effective mechanisms, including knowledge base, in place for mutually beneficial collaboration, enhanced communication and policy dialogue between WHO and civil society organizations

Indicator	Baseline	Target	Achievement
Policy papers, tools, and guidelines on interaction with civil society organizations in use	WHO policy for relations with nongovernmental organizations, as laid down in resolution WHA40.25 and various internal guidance documents	Revised WHO policy on nongovernmental organizations and guidelines for its implementation	Proposal submitted to Fifty-seventh World Health Assembly; guidelines and effective mechanisms drafted Health Assembly requested further consultations

Indicator	Baseline	Target	Achievement
Number of training sessions and seminars on interaction with civil society organizations	Annual meeting of United Nations focal points responsible for relations with nongovernmental organizations Briefing sessions for nongovernmental organizations at governing body meetings	Annual meeting of United Nations focal points responsible for relations with nongovernmental organizations Briefing sessions for nongovernmental organizations at governing body meetings	Participation in United Nations focal point meetings, and in developing guidance for enhancing capacity of the Resident Coordinator system with the United Nations Development Group Briefings of nongovernmental organizations conducted prior to meetings of WHO governing bodies

The proposed new policy on relations with nongovernmental organizations was reviewed by the Executive Board at its 113th session and the Fifty-seventh World Health Assembly, after which it was decided to allow sufficient time for consultations to be held with all interested parties in an effort to reach consensus. The matter would then be dealt with at a future Health Assembly.[1] Meanwhile, the existing policy continued to be implemented with the Executive Board reviewing triennial reports on collaboration or on the status of relations between WHO and some 152 nongovernmental organizations in official relations with WHO, as well as applications for admission into official relations. Regional offices reported strong participation by civil society organizations in ministerial conferences, strengthened collaboration with civil society at country level and, in the Region of the Americas, the development of guidelines for working with the private sector.

Success factors and impediments

Success factors

- Increasing awareness by international and national decision makers of the importance of health development in poverty reduction.
- Privileged relationship of WHO with national health authorities.
- Increased recognition by partners of WHO's technical and coordinating role in international health.
- Active involvement of country offices in United Nations Development Assistance Framework and Common Country Assessment processes.
- Reorganization of resource mobilization and resource coordination structures created an opportunity for better alignment of financial resources and improved implementation of the programme budget.

Impediments

- Uneven distribution of voluntary resources due to earmarking.
- Complications arising from collaboration with the private sector because of the wide variety of actors and types of interaction involved as well as WHO's decentralized structure.
- Dearth of clear guidelines to assist WHO Representatives work effectively with United Nations country teams.
- Lack of criteria by which to define WHO's role, the nature of its involvement in partnerships and the extent of its accountability in the partnerships it hosts.

Lessons learnt in 2004-2005 and how they will be applied in 2006-2007

- Funding of the programme budget and alignment of resources can be improved through coordinated, simplified and harmonized approaches towards WHO partners. In an effort to improve harmonization and alignment, a working group composed of representatives from voluntarily contributing Member States will continue its work.

[1] See document WHA57/2004/REC/3, summary record of the fourth meeting, section 7.

- It is important to ensure that there is full political consultation and that agreement is reached on policy before further action is taken, as was the case with the revised policy on collaboration with nongovernmental organizations. Greater use should therefore be made of informal consultation mechanisms.
- More forceful execution of the policies, norms and standards for health interventions adopted by the Health Assembly is required in the context of public-private partnerships; more formal guidance will therefore be provided in the future to define roles in public health activity with the private sector.

Approved budget and actual expenditure

		Approved budget	Actual expenditure		
			Regular budget	Other sources	All funds
Total 2004-2005 (US$ thousand)		38 264	19 016	9 720	28 736
Percentage	countries	8	0	1	1
	regions	46	45	57	49
	global	46	55	42	50

PROGRAMME PLANNING, MONITORING AND EVALUATION

WHO objective(s)

To assure fully functional, Organization-wide mechanisms for results-based management and effective administration, anchored in WHO's corporate strategy.

Indicator(s) and achievement

- *An increase in the proportion of expected results that are fully met.* The proportion of expected results for which targets were established and fully met was 53% in 2004-2005, compared with 24% in2002-2003.
- *Reduction in the number of ad hoc programme evaluations requested by stakeholders, as an expression of confidence in the Organization's evaluation framework.* The number of evaluations outside the WHO evaluation framework decreased from 14 in 2002-2003 to 12 in 2004-2005.

Main achievements

- Significant progress was made on renewing the results-based management framework, including initiation of the formulation of a six-year medium-term strategic plan 2008-2013.
- A mid-term review of progress towards the achievement of expected results involving a balanced "scorecard" approach was successfully introduced across the Organization at the end of 2004.
- Upgrades of the Activity Management System and equivalent systems were introduced and input provided by all regional offices and headquarters to the design of the integrated global management system.
- The Activity Management System was successfully deployed to all country offices of the African Region.
- Consultations on the Eleventh General Programme of Work were conducted in all regions.
- Peer review mechanisms introduced at headquarters and in some WHO regions helped to improve the quality of strategic and operational plans.

Illustration of selected achievements

In the South-East Asia Region, "Countries' Days" were conducted for nine of the Region's 11 countries. The WHO Representatives, country staff and representatives from the health ministries were invited to the Regional Office for three days of discussions with Regional Office staff (in some cases with headquarters staff also present) on expected results and country workplans. This provided an opportunity for countries to describe their specific needs and for Regional Office staff to outline commitments to the country offices.

Achievement of Organization-wide expected results

Uniform and consistent processes for planning, budgeting, monitoring, reporting and evaluating programmes integrated into the daily operation of programmes at all levels of the Organization: headquarters and regional and country offices

Indicator	Baseline	Target	Achievement
Areas of work at headquarters, and regional and country offices having developed workplans and prepared monitoring reports at regular intervals and following established guidelines	All areas of work participated in the Organization-wide end-of-biennium programme budget performance assessment following established guidelines	All areas of work participate in the Organization-wide end-of-biennium programme budget performance assessment and the mid-term review following established guidelines	All areas of work participated in the Organization-wide end-of-biennium programme budget performance assessment and the mid-term review following established guidelines. All regions reported that budget, workplans and monitoring reports were prepared in line with established guidelines albeit to varying degrees, especially as regards monitoring

Uniformity and consistency improved during the biennium. However, workplan monitoring and monitoring of progress towards the mid-term achievement of expected results was not uniformly conducted at all offices and aggregation of monitoring results was not conducted in line with the Organization-wide process in the Region of the Americas. Standard reporting formats are now in place for both the mid-term and end-of-biennium performance assessment at regional and headquarters levels, but are

not yet established at the country level. As regards workplan consistency, significant improvements were recorded at headquarters owing to the introduction of a peer review mechanism, training efforts, and direct support through a help desk. Progress towards development of a "one country" plan has also been recorded, especially in the European and South-East Asia regions, albeit without full input of headquarters into the planning process.

A culture of results-based management practices introduced at all levels of the Organization

Indicator	Baseline	Target	Achievement
Number of staff at all organizational levels trained in results-based management principles	Zero	500 staff members	At least 620 staff members

Progressive improvement in overall understanding and acceptance of results-based management practices and principles is reported in all regions and at headquarters. Training materials were updated and improved in some regions, with training modules modified to incorporate gender-sensitive planning elements in the Eastern Mediterranean Region.

An effective programme management information system in operation, in support of efforts to achieve greater accountability and better performance in the Organization

Indicator	Baseline	Target	Achievement
Day-to-day use by programme managers at all organizational levels of a remodelled and user-friendly management information system	None	75% of programme managers	Precise percentage not known

The use of management information systems and their user-friendliness continue to vary across regions and at headquarters, with some offices reporting broad acceptance and use, while others report that many programme managers prefer to rely on improvised solutions rather than WHO information management systems to organize their planning, budgeting and monitoring. However, significant improvements in management information systems are reported at headquarters and in the South-East Asia Region through upgrades to their activity management systems. In the European Region, full systems support has not been provided to meet certain monitoring and assessment requirements, resulting in a negative impact on reporting. Designation of the Activity Management System as a legacy system pending introduction of the integrated global management system has already begun to affect systems' compliance with user requirements.

Evaluation system in operation, covering both implementation of successive programme budgets and specific areas of work or themes at all levels of the Organization

Indicator	Baseline	Target	Achievement
Degree of governing body satisfaction with the depth and breadth of coverage and reporting on evaluations and assessment of results at all organizational levels	Clearer articulation of WHO evaluation framework requested	Expression of support by the Executive Board and Health Assembly for evaluations and assessment undertaken	Results of evaluations carried out and follow-up to such evaluations reported to the Programme, Budget and Administration Committee. Regional committees satisfied with evaluations and assessments conducted, with evidence of increased satisfaction in some regions (e.g. Region of the Americas)
Extent of application to future programme budgets and general programmes of work of lessons learnt from evaluations	Not established	Not established	Lessons learnt from different types of evaluations transmitted to management to identify significant common trends for use in budgets and planning

The Programme, Budget and Administration Committee of the Executive Board welcomed the increase in capacity in the units dealing with evaluations and assessment and the work completed during the biennium, although further follow-up work was requested to implement the recommendations made and lessons learnt. Regional committees have been satisfied with evaluations and assessments conducted during the biennium, with evidence of increased satisfaction in some regions (e.g. the Region of the Americas).

An evaluation system is in operation in all regions. However, no specific evaluations were conducted in the African Region during the biennium. A regional programmatic evaluation on noncommunicable disease prevention and control was conducted in the Western Pacific Region, and the South-East Asia Region reports that increased emphasis on results and accountability is

required during evaluation. In the European Region the discipline of evaluation has been upgraded through in-house and external training and the establishment of an internal task force on evaluation.

Success factors and impediments

Success factors

- An effective Organization-wide network of planning officers has permitted global input into the design of the renewed managerial framework, the global management system and other important development initiatives.
- Consistent senior management support for initiatives to promote change was introduced within this area of work.
- Connectivity improvements permitted more timely communication with countries, notably in the African Region.

Impediments

- Lack of a "real-time" tool impedes timely financial monitoring.
- Complex earmarking and financial procedures of some donor organizations hinder efficient resource allocation and alignment of voluntary contributions with the programme budget.
- Insufficient resources were made available to cover the full range of activities, especially as regards evaluations in the African Region.
- Integration of information systems continues to be weak throughout the Organization.
- A perception of planning and reporting overload is reported in some regions and at headquarters.
- An increased emphasis on evaluation has been deemed significant in the European Region and will be further strengthened in 2006-2007, possibly with the permanent involvement of external partners.

Lessons learnt in 2004-2005 and how they will be applied in 2006-2007

- Further strengthening of results-based management across WHO requires strong interventions at all levels of the Organization as well as with Member States. Increased efforts in this regard will be required in 2006-2007 in support of the renewed managerial framework and the formulation of the medium-term strategic plan.
- Information systems enhancements must be properly explained to users and, in parallel, management culture and practices must be improved to make better use of the information management systems. This will have to be kept in mind during the launch of the global management system in 2007.
- It is recognized that effective interaction between countries and regional offices is crucial to effective implementation and should be strengthened in 2006-2007.
- Sustained training and refresher courses continue to be required in support of results-based management and should be expanded in the coming biennium.
- Organization-wide expected results and regional expected results by area of work are often not consistent with programmatic realities at country level. It is hoped that country alignment with the business model will be improved with the introduction of strategic objectives and a more limited number of Organization-wide expected results as of 2008.

Approved budget and actual expenditure

		Approved budget	Actual expenditure		
			Regular budget	Other sources	All funds
Total 2004-2005 (US$ thousand)		11 326	6 244	4 187	10 431
Percentage	countries	3	2	0	1
	regions	48	60	33	49
	global	49	38	67	50

HUMAN RESOURCES DEVELOPMENT

WHO objective(s)

In support of the corporate strategy, to provide effective and efficient human resources services in a timely manner.

Indicator(s) and achievement

Operational excellence in the timely delivery of high quality human resources services at headquarters and regional and country offices. The quality and timeliness of human resources service delivery have been tackled through improved availability of information on human resources policies and procedures; supporting the alignment of strategic work outcomes and staff skills and knowledge through reprofiling; and increased and active involvement of managers in a range of human resources processes including human resources planning, performance management and staff development.

Main achievements

- The competency framework was implemented globally and integrated into major human resources functions.
- The Global Leadership Programme was successfully launched.
- Global Learning Committee agreement was secured on the Organization-wide learning strategy and funds were allocated to regional, country and headquarters offices.
- Human resources service delivery was improved through better planning policies, streamlined recruitment and classification processes accompanied by the introduction and enhancement of user-friendly e-tools, and the integration of staff service functions with streamlining of policies, procedures and processes.
- The e-guide and pilot e-performance management and development system were successfully launched.
- The re-profiling of headquarters, regional and country offices was supported by human resources staff globally.
- Supportive measures for staff were provided through enhanced entitlements such as paternity leave and improved staff health insurance entitlements for temporary staff, endorsement of a special operations approach strategy by the Executive Board.[1] Staff awareness of HIV/AIDS in the workplace was raised by means of workshops and learning materials. Enhanced support was also provided through the focusing of medical services.
- Global human resources support was provided and participation in process mapping was conducted as part of the Global Management System.

Illustration of selected achievements

The WHO competency model was introduced in the European Region as part of the piloting of the e-performance management and development system, and in staff development through participation of senior management in the Global Leadership Programme. The contract review exercise was also completed in the European Region during the biennium, resulting in an increase in fixed-term staff from 40% to 60%, a greater diversity of nationals from unrepresented and underrepresented countries, and a rise in the number of female staff.

Achievement of Organization-wide expected results

Key elements of the human resources strategic framework implemented globally and operating efficiently and effectively, including human resources planning, and streamlined recruitment and classification processes and any further requirements identified through monitoring

Indicator	Baseline	Target	Achievement
Timely provision of high-quality human resources services	Draft strategy circulated	Endorsement and implementation of proposed recruitment strategy	Improved global human resources recruitment outcomes in terms of quality and diversity targets

[1] Document EB115/45.

Indicator	Baseline	Target	Achievement
Effective workforce planning, in particular, increased recruitment of women and nationals from unrepresented and underrepresented countries	Selection of women to P posts at 38% No consistent and comprehensive approach to human resources planning	Facilitate achievement of 50% target for recruitment of women and 60% target for developing country nationals Concept paper agreed and human resources planning template accepted for global approach	Particular consideration of women candidates for inclusion on shortlist now normal practice Increasing use of and positive feedback from users of the ePOD electronic position management tool and new Master Standard, an enhanced e-recruitment system
User satisfaction with human resources services	No recognition	Increased motivation of staff through staff friendly policies Provision of a supportive network	Positive feedback from staff regarding increased staff entitlements in staff health insurance for temporary staff and paternity leave Recruitment strategy noted by Executive Board Implementation of the special operations approach

During the biennium, electronic recruitment was introduced in all the regional offices. Installation and training were provided and competencies assessment was integrated into the selection system. A recruitment strategy was also developed and noted by the Executive Board.[1] In 2005, a working group was established to review existing selection procedures at headquarters. The group's recommendations relating to streamlining have been reviewed and are being introduced. In addition to the training provided on the new Master Standard, managers and human resources staff at headquarters were provided with the electronic position management tool to facilitate online writing and classification of job descriptions and vacancy notices. The implementation of the strategic direction and competency review at headquarters was part of the strategy to ensure a solid organizational design and workforce planning. This process is being supported by the human resources planning and management tools. As regards HIV/AIDS in the workplace, achievements have been made under the United Nations-wide ACTION programmes and post-exposure prophylaxis (PEP) Kits initiatives, as well as under the HIV/AIDS learning and orientation strategies. A major change was introduced to the staff health insurance rules and regulations concerning the eligibility of short-term staff and their dependents for insurance coverage, and orientation sessions have been launched at headquarters to raise staff awareness. A working group on harassment was established at headquarters in 2004 to identify means of dealing effectively with any form of harassment. The working group has submitted its report and recommendations which are being reviewed. Paternity leave changes, as recommended by the International Civil Service Commission, were noted by the Executive Board. The special operations approach for all WHO internationally assigned staff was implemented in accordance with United Nations common system guidelines. Staff services functions were consolidated in order to provide prompter, more responsive and proactive services and advice to staff and management. A one-stop staff orientation service was also established at headquarters and human resources processes and procedures were simplified and streamlined. Capacity to provide expert advice on entitlements was enhanced, thus increasing staff satisfaction. The Joint Medical Service in Geneva was dissolved and the independent Health and Medical Service established in order to focus resources on services rather than administration. WHO also took the lead in the development of United Nations Medical Services staff contingency plan guidelines for an influenza pandemic. Peer counselling and support were provided during the biennium, including stress management and outplacement services in the context of the strategic direction and competency review exercise.

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

Core functions of a human resources information system designed and relevant processes re-engineered

Indicator	Baseline	Target	Achievement
Design validated at all levels of the Organization	Human resources information difficult to locate: too many sources	Accessible user-friendly human resources information Implementation of electronic system	Successful launch of e-guide in September 2005 Human resources process mapping for Global Management System completed

The human resources e-guide was launched in September 2005 and brings together information in an accessible, searchable database. The introduction of the electronic position management system permits tracking of and reporting on classification actions to be carried out. Staff from headquarters and selected regions took part in business process mapping of human resources processes for the Global Management System.

Organization-wide strategy for leadership and staff development implemented, monitored and systematically evaluated

Key competences framework implemented globally and integrated into major human resources functions (recruitment, performance and staff development)

Indicator	Baseline	Target	Achievement
Improvement in job performance in support of organizational goals	Data unavailable in systematic way for headquarters, regional offices and country offices	e-performance management and development system to be piloted in headquarters, 2 regional offices and 2 country offices in 2005 Global learning programmes linked to the core competencies to be developed Managerial and leadership competencies to underpin the design and evaluation of the Global Leadership Programme Senior managers to complete a 360° evaluation and a personal development plan as part of the Global Leadership Programme	e-performance management and development system provides reports on compliance; piloted in headquarters, 2 regional offices and 2 country offices; this allows baselines to be set for improvement in 2006-2007 Global learning programmes successfully introduced including 360° evaluation Staff survey on perceptions of various aspects of management, performance and learning was undertaken in 2005 and will set baseline for 2006-2007

Indicator	Baseline	Target	Achievement
Effectiveness of key competences framework and related applications, including performance management and development, and rotation and mobility	Competencies not integrated	Competencies fully integrated into main human resources processes	Key competency framework implemented globally and integrated into: – job design – recruitment and selection – performance management and – staff development programmes

The Staff Development Fund and Global Learning Committee were established and funds were allocated at headquarters, regional and country levels. Programmes delivered by all parts of the Organization were reviewed by the Global Learning Committee in late 2005 – the first such exercise. The Committee has agreed on a global statement on staff development in WHO, priority areas and target audiences for 2006-2007, and an accountability framework for staff development.

Success factors and impediments

Success factors

- Dedicated and competent human resources staff.
- Dedicated resources for human resources management and development, and support from senior management.
- Focus within the United Nations system on human resources management.

Impediments

- The strategic direction and competency review exercise required strong support in terms of staff time and resources.
- There needs to be a considerable shift in the organizational culture to generate support for the new approach to learning across WHO. Changes, to which staff and senior managers appear to be receptive, will take several years to become embedded in WHO's working methods.
- Implementation of a staff rotation and mobility scheme has been postponed because of resource constraints.
- The position management process cannot be developed fully before completion of the Global Management System design phase.
- Efficiencies are not maximized on account of outdated systems.
- The postponement of a global staff/management council meeting due to the decision by the United Nations General Assembly to delay its review of the International Civil Service Commission's recommendations.

Lessons learnt in 2004-2005 and how they will be applied in 2006-2007

- In the short, medium and long term, the Organization needs to focus its efforts in a more sustainable, strategic and outcome-oriented manner while ensuring there is dialogue with stakeholders at all levels. This will require more regular meetings with directors, managers, management support units and human resources staff and staff associations globally in order to seek their views and inputs on key human resources policy issues.
- The human resources profile must be made more visible through the provision of advice and guidance to staff and managers, and by improving managers' ability to deal with management issues through the Global Leadership Programme, as well as functional literacy and learning programmes.
- The Global Management System will act as a main catalyst for defining the delegation of authority and accountability matrix in all human resources related transactions.
- The framework for shared responsibilities for staff development establishes an excellent foundation. In addition, the review of staff development activities undertaken across WHO indicates that there should be a more sustainable and strategic approach to staff development activities in 2006-2007. The Global Learning Committee has set six priority areas and target audiences for 2006-2007. It is seeking to change the way staff development funds are allocated in order to provide incentives for learning in these areas.
- The Global Leadership Programme is operational and will continue in 2006-2007. There will be new activities for current participants and a new group beginning in early 2006. A staff survey measuring how staff view managers and leaders was

undertaken in mid 2005. Responding to the results of the survey will be a priority for the next biennium with management performance a key issue.

- Operations need to be maintained while developing and adapting to new systems and coping with resource constraints. Ensuring that the right competencies are in place will be critical in this regard.

Approved budget and actual expenditure

		Approved budget	Actual expenditure		
			Regular budget	Other sources	All funds
Total 2004-2005 (US$ thousand)		34 912	16 647	21 233	37 881
Percentage	countries	3	0	0	0
	regions	38	46	37	41
	global	59	54	63	59

BUDGET AND FINANCIAL MANAGEMENT

WHO objective(s)

To follow best practice in financial management coupled with integrity and transparency, providing effective and efficient support for financial administration across the Organization for all sources of funds, including relevant financial reporting at all levels, both internally and externally.

Indicator(s) and achievement

- Acceptance by governing bodies of the biennial financial report, audited financial statements (including an unqualified audit opinion) and the interim financial report and statements.
- Budget implementation and monitoring that enables Member States and other donors to judge financial performance. *Financial statements including external audit opinion will be presented in May 2006 for review and approval by the Health Assembly.*

Main achievements

- Income and expenditure at record levels, including a 40% increase in voluntary contributions, were successfully processed, recorded and reported during the biennium.
- Good progress was made in the development of policies, with a view to laying the foundation of the new integrated management accounting and administration system within the global management system.
- Improvements in corporate governance were introduced with the issuance of the fraud prevention policy and the accountability framework.
- New financial policies for income and expenditure were developed for implementation in 2006. These changes expedite the release of income for programme implementation and for expenditure, and move towards the delivery principle, i.e. that accounting of expenditure will match results achieved.
- A continuing highly effective currency protection strategy ensured that the Organization was largely protected from the weaker US dollar.
- Statutory financial reporting was successfully completed in accordance with agreed deadlines.

Illustration of selected achievements

The earthquake and tsunamis of December 2004 presented the biggest single challenge for the financial management processes in 2004-2005. Funds quickly reached headquarters, the Regional Office for South-East Asia and the affected countries and processes for transparent handling had to be set up without impeding the relief effort. The most important challenge was to find experienced staff to control and monitor the flow of funds. Staff from the South-East Asia Region made personal sacrifices to work in the field for months at a time at short notice. Simplified routines for taking deposits, moving cash and making and recording payment were put in place without loss of accountability. Several months after the disaster, when donors began to request accounts of their contributions, the early actions that had been taken facilitated production of the detailed financial reports required by donors.

Achievement of Organization-wide expected results

Budget monitoring, accounting and financial reporting in operation on the basis of modern business rules and practices within a sound internal control framework in accordance with WHO Financial Regulations and Financial Rules, policies and procedures, making it possible to judge the Organization's output, in relation to budget, level of implementation, and expected results for all sources of funds

Indicator	Baseline	Target	Achievement
Timeliness of provision of information	95% of donor financial reports produced on time Statutory financial report produced by end of March	100% 1 week earlier	100% Achieved in 2004
Accuracy of information	100% accuracy and Financial Regulations and Financial Rules respected	100% accuracy and Financial Regulations and Financial Rules respected	100% accuracy and Financial Regulations and Financial Rules respected
Acceptance by donors of timely and accurate financial reports	Financial report in line with specific donor needs, but low level of acceptance of standard financial reports as proxy for specified reports	Increased acceptance by donors of standard financial report	Good progress in achieving increased acceptance
Level of implementation of audit recommendations	100% implemented	100% implemented	100% implemented

Effective budget monitoring, accounting and financial reporting were achieved during the biennium. Financial reporting to donors was improved through close collaboration with donor representatives and increased use of standard formats. Appropriate financial statements were prepared on a timely basis, providing transparent financial reporting on WHO implementation. All internal and external audit issues arising during the period were adequately addressed. Improvements continue to be made in the area of timely provision of financial information and timely and effective reporting of management. While all audit recommendations were implemented, there were instances of considerable delay. Tracking mechanisms require improvement to permit better reporting and monitoring of such delays.

Financial resources of the Organization effectively managed within acceptable liquidity and risk parameters in order to maximize their potential

Indicator	Baseline	Target	Achievement
Level of earnings on liquidity as compared to accepted benchmarks	Actual performance in 2002-2003 relative to benchmark	To exceed benchmark	Overall performance at benchmark, although short-term funds were approximately 0.4% below benchmark and long-term funds slightly above.
Efficiency of banking operations	Actual bank charges in 2002-2003. Accuracy of payment to bank accounts	Reduced bank charges 100%	Achieved with beneficiaries correctly paid on time. 100%
Protect the currency risk efficiently for major currencies of expenses other than those in US dollars by using hedging strategy	Actual United Nations exchange rates in the biennium	Exchange rate assumed in the standard costs used for budgeting	Hedging gains of US$ 30 million which largely bridged the gap between the actual and budget exchange rates

Good performance was achieved with respect to management of surplus liquidity, arising both owing to the time lag between receipt of donor funds and implementation, and to long-term financial reserves such as the Staff Health Insurance Fund. The monitoring of investment performance, accounting and reporting was successfully delivered through the global custodian. Total investment earnings for the biennium were US$ 70 million, the overall percentage return being in line with benchmark. Short-term investment performance versus benchmark (3-month US dollar LIBOR) was adversely affected by a slightly longer-than-benchmark investment maturity profile, adopted for strategic reasons in order to guarantee a minimum level of investment earnings. This longer profile slightly delayed the benefits to WHO of rapidly rising US dollar short-term interest rates in 2005. Foreign exchange protection measures resulted in US$ 30 million cashflows to offset the effect of the weaker dollar on the value of the regular budget. The implementation of an Internet banking system in some regional and country offices resulted in faster payments to beneficiaries with reduced bank fees. The implementation of a new banking payment mechanism at headquarters centralized a large number of payments previously made through country offices, thereby reducing their workload.

Effective and responsive financial administration of supplier contracts, claims, staff salaries, entitlements, benefits and retiree benefits

Indicator	Baseline	Target	Achievement
Timeliness and correctness of payments to staff and retirees according to their respective compensation/benefits package, suppliers and contractors in accordance with their respective contracts, and claims in accordance with entitlements rules	Not established	Not established	Despite significant resource constraints, policy and procedural steps have been taken to address delays in staff travel payments in headquarters. Some issues still to be addressed in 2006-2007.

Payments to staff and suppliers were correctly processed, but further improvements can be made in terms of efficiencies and reduction of backlogs, in particular with respect to headquarters travel claims.

New, integrated financial management and reporting systems developed on the basis of modern business rules and practices that allow staff in all locations and at all levels to have access to the financial information necessary to enable them to meet their objectives

Indicator	Baseline	Target	Achievement
Testing and sign-off on new systems	Existing financial systems	Identify and implement ad hoc improvements	Interoffice accounting voucher and country office imprest systems implemented successfully
Consistent services and information across all sources of funds and areas of work	Some differences between financial systems in regions and at headquarters	Differences eliminated	New accounting policies and procedures for income and expenditure developed and finalized. Policy work initiated for standard costing. These developments contribute to system and procedure standardization across the Organization
	Inconsistent provision of field-level financial information owing to system limitations	Improved timeliness of field-level financial information	Not achieved

Good preparatory work was done in respect of new financial policies and procedures, laying the foundations for the global management system project.

Success factors and impediments

Success factors

- Numerous manual accounting transactions and reconciliations were automated in order to enhance the efficiency of the financial operations while improving their accuracy (notably the imprest accounting systems used at country level).
- Active regional participation in global management system reviews, assessments and consultations built good foundations for the global management system project.

- Internal and external audits were successfully coordinated, with no major audit issues outstanding at the end of the biennium.

Impediments

- Lack of capacity to train staff in the implementation of WHO financial rules and procedures reduced efficiency and effectiveness, particularly at country level.
- System inadequacies, such as lack of consistency between accounting and management of financial information, lack of integration and failure to integrate field-level systems with regional and headquarters levels, adversely affected the ability to produce timely management information.
- Connectivity issues in some field offices delayed recording of transactions.
- Failure of some field offices to adhere to established policies and procedures resulted in erroneous issuance of obligation documents.
- Exchange rate fluctuations caused significant variations between staffing and other costs as initially planned and those actually incurred in dollar terms: although such fluctuations are managed at a macro-level through hedging, at programme implementation level, distortions occur between actual and budgeted assets, thereby distorting management reporting.
- Resource constraints brought pressure to bear on certain accounting functions in some offices (e.g. staff personal accounts) and prevented improvements in reporting and monitoring of budget implementation.

Lessons learnt in 2004-2005 and how they will be applied in 2006-2007

- Development of realistic work plans is important and serves to enhance budget implementation. More time was therefore devoted to work plan development for 2006-2007.
- The global management system project progressed slowly in 2004-2005 but will accelerate in 2006-2007. Significant efforts are being made to clarify and improve the delegation of authority that will be facilitated by the new system.
- Funding and delegated authority will continue to flow from the centre to regions and countries. Capacity building in the form of additional staff and upgraded skills will therefore be required.
- It is important to continue to provide monthly reporting on the status of implementation for all sources of funds in order to ensure rapid implementation of donor-funded projects.
- It is important to continue coordinating with all staff responsible for the clearance of agreements and timely receipt and recording of voluntary funds so as to facilitate quick implementation.
- Integrated financial management must be well planned and coordinated with all parties before implementation. Efforts will therefore be made to continue enhancing communication and coordination with clients to ensure transparency, effectiveness and efficiency of operations.
- Training of country and regional office staff on financial rules and procedures is extremely important and needs to be conducted on a sustainable basis. Training packages will therefore be further developed to enable more staff from technical units and WHO country and regional offices to receive basic financial and accounting training.
- Improvements in timeliness of payments to staff and suppliers are needed, and will come with the improved systems and changes in business rules to be introduced in connection with the global management system.

Approved budget and actual expenditure

		Approved budget	Actual expenditure		
			Regular budget	Other sources	All funds
Total 2004-2005 (US$ thousand)		43 841	21 363	22 296	43 659
Percentage	countries	0	0	0	0
	regions	40	45	35	40
	global	60	55	65	60

INFRASTRUCTURE AND INFORMATICS SERVICES

WHO objective(s)

To ensure access to timely and effective infrastructure, procurement and logistical support in order to facilitate implementation of technical programmes at all organizational levels.

To provide a well-managed information and communication technology environment responsive to the needs of all users.

Indicator(s) and achievement

Appropriateness, cost-effectiveness and reliability of infrastructure and logistics support services at all organizational levels. Services provided throughout the biennium were reliable and rapid and efforts to realize further improvements were maintained.

Increase in proportion of computerized systems commonly used in WHO offices based on approved global strategic and operational plans. The number of common systems used at headquarters and regional levels expanded during the biennium and the scope of such systems already in place was enhanced; examples include systems for purchasing, travel, staff performance management and recruitment. The emphasis has been on the Global Management System, to which resources are being channelled in preference to others areas.

Main achievements

- There was active Organization-wide participation in work on the Global Management System, the country connectivity project, global information technology security, the WHO identity management system, and the WHO information technology application/product inventory.
- The country connectivity strategy was completed and the draft WHO global information and communication technology strategy was prepared and is ready to be submitted for consideration by Member States.
- Connections to the Global Private Network, the Organization-wide area network, increased significantly.
- Competitive prices were obtained for goods through the e-procurement system and WHO catalogues.
- Security information systems for staff tracking were improved.
- Significant improvements were achieved in information technology systems, such as those concerning access to e-mail and telephony for travellers, virtual work spaces, and security for workflow management applications.
- Response to emergencies, such as floods, earthquakes, tsunamis and new, emerging and re-emerging diseases was rapid and effective.
- At headquarters, the Strategic Health Operations Centre and annex office area were created, inaugurated and used in a number of crises, including the Indian Ocean earthquakes and tsunamis of December 2004.

Illustration of selected achievements

As a first step towards a strategic approach to managing and maintaining WHO's real-estate assets, an Organization-wide ten-year capital master plan was developed that includes the maintenance, transformation, construction and renovation work that will be required to maintain the overall viability, physical condition and security of the buildings over the next 10 years. An initial phase of construction work, involving the completion in 2005 of the new building for the Regional Office for the Western Pacific, was of importance to the Western Pacific Region as a whole. The second phase, covering renovation of the original building, retrofitting of existing facilities and re-grading of the driveway, will continue during 2006.

Achievement of Organization-wide expected results

Appropriate and cost-effective infrastructure, procurement and logistic support maintained for the smooth operation and security of established offices

Continuing support provided for programme delivery in a rational and sustainable manner

Indicator	Baseline	Target	Achievement
Degree of satisfaction with daily operations of all offices resulting from reliable and effective infrastructure support services	No satisfaction survey	Satisfaction survey conducted by end of 2005	The degree of satisfaction in most offices continues to be maintained or improved
Minimum time for delivery of goods from request to arrival in country of destination	6 months	4 months	3.5 months on average. The deployment of the e-procurement requisitioning system to all regional offices, headquarters and a large number of country offices has reduced the procurement cycle substantially

The smooth operation and security of established offices was ensured as planned through periodic checks and reviews of the applied systems and was supported by maintenance contracts. In addition, adequate periodic maintenance of the premises and enhancement of security measures have contributed to the overall security and appearance of the regional offices. There is still a shortage of office space in the WHO regional offices for Africa, the Americas, South-East Asia, the Eastern Mediterranean and the Western Pacific, while a staff survey at headquarters identified office space management as an area of concern and dissatisfaction. The degree of customer satisfaction was evaluated on the basis of the number of complaints received or by means of a staff survey.

Continuing support provided to global governing bodies and technical meetings in the form of efficient preparation and logistical support, including the availability of WHO documents in a timely manner

Indicator	Baseline	Target	Achievement
Member States' satisfaction regarding the efficient and effective servicing of meetings	No satisfaction survey	Survey conducted	No formal satisfaction survey was conducted. However, comments received before, during and after respective meetings indicate that preparation and coordination of global-, regional- and country-level meetings continues to be appreciated

Global and regional governing bodies meetings and technical meetings at all levels of the Organization were efficiently prepared and smoothly conducted. Facilities and services were also provided for other large meetings, such as those on the WHO Framework Convention on Tobacco Control, the revision of the International Health Regulations, avian influenza and human pandemic influenza and other emerging health issues. For some meetings document distribution was later than desirable, however this was largely due to the late finalization of the documents following a short preparation time for the meeting. Efforts to streamline logistic support services by critically reviewing the services provided and issuing guidelines, checklists and timetables, have helped to contain costs. A thorough review of document distribution practices will reduce production costs in the next biennium.

Health supplies of the highest quality at the best price procured for technical programmes and Member States, using mechanisms such as umbrella agreements and electronic commerce to promote a more autonomous method of purchasing

Indicator	Baseline	Target	Achievement
Volume of direct procurement carried out by all WHO offices based on centrally negotiated contracts, resulting in lower per-unit costs (economies of scale)	No facility available.	30% of procurement based on centrally negotiated contracts	More than 40% of total procurement throughout the Organization was under centrally negotiated global agreements

Indicator	Baseline	Target	Achievement
Increased level of reimbursable procurement	US$ 16 million	Double the baseline amount of reimbursable procurement	Reimbursable procurement on behalf of governments, nongovernmental organizations and sister United Nations agencies has more than doubled compared with the previous biennium
Frequency of use of mechanisms available at country level	12 000 orders placed by regions and countries	25% increase in orders placed by regions and countries	Increase in country and regional procurement was 30% after online WHO e-catalogues made accessible globally

Efforts to procure quality health supplies at the best prices were promoted throughout WHO using various mechanisms. Significant cost benefits have been achieved through direct and indirect-cost avoidance. Autonomous purchasing has increased in many regional and country offices through the use of WHO's e-procurement system. The use of WHO catalogues has increased the benefits derived from umbrella agreements with regional suppliers, further amplifying WHO's purchasing power.

Global strategic and operational plans for information and communications technology designed and implemented

Indicator	Baseline	Target	Achievement
Adoption of strategic information and communication technology plans for telecommunications and corporate systems in WHO, with functioning operational plans at headquarters and regional levels	No global information and communication technology strategy in place. All regions aiming to develop regional office strategic information and communication technology plans	Strategic and operational plans developed and submitted to governing bodies for consideration	Work on WHO's global draft information and communication technology strategy completed, with contributions from all regional offices. Draft strategy ready for presentation to governing bodies. Regional Office for the Americas has completed the development of a region-wide process to define the regional information technology strategy
Approved emergency telecommunications plans and infrastructure in place across WHO	No emergency plans and infrastructure available	Emergency plans and infrastructure in place in headquarters and all regional offices	Plans and infrastructures are in place in the regional offices for the Americas and South-East Asia and at headquarters

Two global information and communication technology plans have been completed during the biennium. The first, the country connectivity strategy, provides the framework for the country connectivity project. Under the framework, 85 country offices were connected during the biennium. The second, the WHO global information and communication technology strategy, is still in draft form and is awaiting ratification by a global information and communication technology committee that will be established shortly. Emergency plans for information and communication technology were implemented in the Regional Office for South-East Asia and headquarters to cope with events arising from the Indian Ocean earthquakes and tsunamis. Global avian influenza preparedness planning has resulted in plans for improved country connectivity and in improved public web site capacity in the case of a pandemic. The WHO Regional Office for the Americas has emergency plans and an infrastructure in place.

Communication network and administrative and technical systems in place linking WHO offices, with a view to improving collaboration and coordination through shared information

Indicator	Baseline	Target	Achievement
Secure access by WHO offices to common databases	25 WHO locations connected to the Global Private Network	100 locations connected to the Global Private Network	85 locations now have Global Private Network connection across WHO. This provides a secure, managed communication channel for the transmission of voice, video and data

Indicator	Baseline	Target	Achievement
Electronic exchange of financial, administrative and health information between WHO offices	Not established	Not established	The country connectivity project is making a significant difference to the ability of many country offices to access information in a secure and reliable fashion

The consolidation of an information technology business continuity plan has progressed and, following negotiations, it was agreed that UNICEF and the Regional Office for Europe will provide mutual support in the case of a disaster at one or other site. New technologies and applications are constantly being developed or acquired, and more attention is being given to global WHO approaches, enabling staff in different locations to share expertise in delivering information across the Organization. As countries benefit from improved connectivity via the Global Private Network, opportunities for implementing systems to support country operations are increasing. For example, financial and personal accounts can now be accessed via the Internet in the Regional Office for Africa. Headquarters and the regional offices for Africa, the Americas and South-East Asia are continuing to increase the availability of applications accessible through the Internet and Intranet. The Regional Office for South-East Asia has created a number of information systems for regional and country offices, including web sites, and has improved the activity management system to meet its requirements. At headquarters and in the regional and country offices research was focused on SharePoint, a collaborative work tool for pooling information in a variety of formats among a range of users both within WHO and beyond. For example, SharePoint is used for the web sites of the Stop TB Partnership and Global Drug Facility as a single platform to permit joint global tracking of drug orders, purchases, invoices and pledges. Many health-related sites, on HIV for example, use SharePoint to disseminate materials and as a data collection tool for teams based in headquarters who use the material to provide better guidance and up-to-date information to colleagues in the field.

Success factors and impediments

Success factors

- Clear guidance and managerial support for the development and implementation of project and initiatives.
- Peer review and good teamwork within and between offices.
- Motivated and dedicated staff.
- High-level recognition of the importance of information technology in facilitating strategic transformation to a knowledge-based learning organization, and the horizontal placement of the information technology function in the organizational structure.

Impediments

- Budgetary reductions and funding delays reduced the time available for planned implementation of projects.
- Increased responsibilities and scope of work, limited human resources and lack of technical skills in certain key areas put excessive pressure on staff members.
- Lengthy and complicated recruitment processes.
- A lack of up-to-date operational techniques restricted service delivery.
- The division of staff and responsibilities between two locations in the Regional Office for Africa.
- Inadequate infrastructure in some offices.
- Ageing buildings that are in need of major repair, renovation and maintenance. Insufficient funds for major work result in incomplete and temporary measures that are costly over time.

Lessons learnt in 2004-2005 and how they will be applied in 2006-2007

- Services (both contracted and not contracted) should be reviewed to ensure their cost-effectiveness during the next biennium. Outsourcing should be considered as a means of reducing and mastering the operational cost and improving performance.
- Standard practices should be identified and replicated in general administration to improve the level of services provided. Keeping all levels proactively involved with projects is also required in order to improve efficiency.

- Consolidated planning for information and communication technology needs the active support of senior managers outside the field of information and communication technology, who must drive the prioritization of business systems in each location.
- Global information and communication technology governance and supporting processes will help the implementation of the global information and communication technology strategy, reduce duplication of effort, and bring WHO's information and communication technology teams closer together.
- Joint negotiations with major airlines to extend the scope of negotiated fares to regions and countries must be continued.
- Systematic records evaluation and assessment must be continued in all offices and units to ensure effective and efficient record-keeping practices, safe storage of important information, and to maximize the use of space.
- It is essential to ensure that projects are adequately resourced before starting implementation.
- Document production and distribution must be improved and simplified.
- Clear and concise work plans are required in the activity management system with financing requirements and limitations that are clearly articulated and understood, while remaining flexible enough to respond to constant changes in priorities.
- The drive towards simpler procedures must continue.
- Support services must be involved from the start of a disaster response phase.
- Information technology and telecommunications must be strategic elements in the development of comprehensive preparedness plans.
- Inventories of essential services and equipment should be maintained.

Approved budget and actual expenditure

		Approved budget	Actual expenditure		
			Regular budget	Other sources	All funds
Total 2004-2005 (US$ thousand)		174 715	90 915	99 232	190 147
Percentage	countries	7	0	0	0
	regions	32	42	36	39
	global	61	58	64	61

DIRECTOR-GENERAL, REGIONAL DIRECTORS AND INDEPENDENT FUNCTIONS

WHO objective(s)

To direct, inspire and lead all offices of WHO so as to maximize their contribution to achieving significant gains in the health status of Member States, aligned to the strategic directions of the corporate strategy, within the overall framework of WHO's Constitution.

Indicator(s) and achievement

Extent of delivery of all areas of work set out in the Programme budget, as reflected in the end-of-biennium performance evaluation. According to the end-of-biennium performance assessment, the proportion of Organization-wide expected results for which targets were established and fully attained was 53% in 2004-2005 compared to 24% in 2002-2003.

Main achievements

- The WHO Framework Convention on Tobacco Control entered into force on 27 February 2005. By the end of 2005, 115 Member States and the European Community had become Contracting Parties.
- The International Health Regulations (2005) were adopted[1] and discussions initiated with Member States on voluntary compliance with selected provisions.
- Since mid-2005, WHO has been alerting Member States to the risk of an avian influenza epidemic among humans should the avian virus mutate into a human virus and a pandemic influenza strategic action plan has been drawn up.
- The strategic health operations centre was established and continues to provide critical support in the relief efforts for the Indian Ocean earthquakes and tsunamis, the south Asian earthquake, the avian influenza epidemic, the humanitarian crisis in the Darfur region of Sudan and outbreaks of Marburg and Ebola haemorrhagic fevers.
- The "3 by 5" strategy, launched in December 2003, helped to triple the number of people receiving HIV treatment in low- and middle-income countries and created momentum towards approaching universal access to treatment by 2010, a goal that was endorsed at the G8 Summit, held in Gleneagles, Scotland in July 2005, and by the United Nations General Assembly at its sixtieth session in September 2005.
- Numerous significant publications, including the world health reports of 2004 and 2005, were issued on, among other subjects, the prevention of chronic diseases,[2] and women's health and domestic violence against women.[3]
- New developments in the formation of partnerships included the launch of the Partnership for Maternal, Newborn and Child Health and the health metrics network, the creation of the International Finance Facility for Immunization and the establishment of the world alliance of patient safety.
- Member States endorsed several key strategies, notably the Global Strategy on Diet, Physical Activity and Health,[4] and the strategy on reproductive health.[5]
- Regional Directors for the South-East Asia and Western Pacific regions were elected in 2004 and for the African and European regions in 2005. The Director-General also appointed two Assistant Directors-General in 2005.
- By the end of 2005, voluntary contributions amounted to US$ 1920 million, an increase of US$ 550 million over the previous biennium. More than 63% of funds were allocated to the regions and Member States.

Illustration of selected achievements

As a result of effective collaboration with Member States and partners and a focused approach by WHO, by the end of 2005 indigenous poliovirus remained endemic in only four countries, and in 15 out of the 21 reinfected countries, the epidemics had been successfully controlled.

[1] Resolution WHA58.3.

[2] *Preventing chronic diseases: a vital investment: WHO global report.* Geneva, World Health Organization, 2005.

[3] *WHO multi-country study on women's health and domestic violence against women.* Geneva, World Health Organization, 2005.

[4] Resolution WHA57.17.

[5] Resolution WHA57.12.

Achievement of Organization-wide expected results

Resolutions and decisions of WHO's governing bodies implemented

Indicator	Baseline	Target	Achievement
Level of endorsement by governing bodies of regular reports on implementation of resolutions and decisions	Full endorsement of all regular reports on implementation of resolutions and decisions	Full endorsement of all regular reports on implementation of resolutions and decisions	Reports from Regional Directors to regional committees, and from the Director-General to the governing bodies were endorsed. Resolutions and decisions of the governing bodies were adopted and have guided the work of the Organization

The Programme budget 2006-2007 was adopted with a 17% increase in the budget and a 4% increase in the level of assessed contributions. During the biennium, decisions were taken on ways in which the Secretariat could improve reporting on progress made in the implementation of resolutions and decisions from previous bienniums, and on additional core elements to be included in resolutions to be presented to the governing bodies, including associated costs.

Greater coherence and synergy established between the work of the different parts of the Organization to implement the Programme budget

Indicator	Baseline	Target	Achievement
Degree of collaboration in defining expected results and workplans and use of cross-organizational systems in their implementation	Inconsistent collaboration across organizational levels in the formulation of expected results and in the conduct of joint work planning	Consistent involvement of regions and countries in the definition of expected results and improved collaboration in joint work planning	A more collaborative programme budget development process took place, including a peer review with country and regional participation. Involvement of all three levels in joint work planning was also improved for many, but not all, areas of work

All the regional offices reported better collaboration over preparation of the programme budget and joint planning. More efficient procedures led to improved coordination between the three levels of the Organization.

Programme delivery carefully stewarded; and impact of the Organization's work evaluated

Indicator	Baseline	Target	Achievement
Extent of action undertaken on the basis of strategic reviews and programmatic, thematic and country evaluations	Not established	To liase with management in accepting and implementing recommendations and lessons learnt	Lessons learnt and recommendations made in the thematic and country evaluations were accepted by management for incorporation in their workplans

Organization optimally administered at all levels

Indicator	Baseline	Target	Achievement
Frequency of implementation of recommendations from internal and external audit	Majority of recommendations implemented	Satisfactory disposition of significant recommendations	The Office of Internal Oversight Services monitors the status of all its recommendations to ensure that actions are effectively implemented by management or that senior management accept the risk of not taking action. The Office is generally satisfied with the overall disposition of the significant audit recommendations. The majority of recommendations from the 2004 and earlier workplans have been reported as implemented, reviewed by the Office for effectiveness and the audits closed

Legal status and interests of the Organization better protected through timely and accurate legal advice and services

Indicator	Baseline	Target	Achievement
Responsiveness to requests for legal advice and services, and frequency of implementation of this advice within the Organization's programmes	Responsiveness affected by insufficient human resources. Frequency of implementation of legal advice overall acceptable	Improved responsiveness in terms of time and accuracy of advice	Human resources situation improved with recruitment of two legal officers, allowing for quicker and more accurate legal advice and a higher rate of implementation by programmes

The process of revising the International Health Regulations was effectively facilitated and supported and, as a result, they were adopted in May 2005.

Approved budget and actual expenditure

		Approved budget	Actual expenditure		
			Regular budget	Other sources	All funds
Total 2004-2005 (US$ thousand)		28 670	24 092	11 521	35 613
Percentage	countries	0	2	0	1
	regions	33	46	10	35
	global	67	52	90	64

WHO'S PRESENCE IN COUNTRIES

WHO objective(s)

To deliver WHO core functions at country level, in line with the corporate strategy, and with a particular focus on the Organization's directing and coordinating role for international health as expressed in the Constitution.

Indicator(s) and achievement

Percentage of WHO resources – staff and funding – allocated to WHO core functions within countries. In the Programme budget 2004-2005 under this area of work, 5.6% of WHO funds were directed to support WHO core functions with countries.

Efficiency and effectiveness with which WHO staff and funding are used, in relation to health outcomes in countries (measured through different types of monitoring and evaluation in the Organization). Ninety per cent of WHO country offices are using country cooperation strategies as a mechanism to deliver WHO core functions efficiently at country level; eight country performance evaluations have been performed and one region has piloted key performance indicators for country work.

Main achievements

- The country focus policy was presented at the 116th session of the Executive Board in May 2005.
- Country cooperation strategies were completed in 130 countries at the end of 2005 and were used to inform 2006-2007 operational planning and to formulate WHO's corporate strategy.
- Delegation of authority to WHO Representatives increased in most regions.
- All 46 country offices in the WHO African Region were linked to the Global Private Network.
- Following the implementation of the country cooperation strategy process, all regions were able to deliver WHO core functions more efficiently at country level: in the Region of the Americas, five key countries were targeted; in the Regional Office for South-East Asia, country reviews were prepared for all countries and delegation of authority to all WHO Representatives significantly increased; in the European Region, the country cooperation strategies linked technical assistance, country work and health system work; in the Eastern Mediterranean Region, 17 such strategies were completed and used to strengthen WHO country presence; in the Western Pacific Region, the first multicountry cooperation strategies were developed in close collaboration with the Regional Office for South-East Asia.

Illustration of selected achievements

In 2004, the Regional Office for Africa and headquarters jointly developed a framework for strengthening WHO's technical support to countries in order to help improve health outcomes in the African Region; this led to the development of the "one country" plan and budget. Drawing on lessons from this process, an ambitious programme to build the country team capacity for reprofiling all 46 WHO country teams in the African Region was initiated. In 2005, at a workshop held in Maputo, it was decided to strengthen innovative joint planning across the three levels of the Organization with a view to achieving universal coverage and access to essential health services in 13 African countries.

Achievement of Organization-wide expected results

WHO's strategies and the allocation of technical and financial resources, including staffing at country level, in line with country cooperation strategies

Indicator	Baseline	Target	Achievement
Existence of analytic documents to inform the development of the next WHO corporate strategy, general programme of work and proposed programme budget	92 country cooperation strategies conducted. No global analysis of strategies available	Scale up the country cooperation strategy process and ensure global analysis in place	130 country cooperation strategies conducted. One regional analysis carried out. One global analysis informed the Eleventh Global Programme of Work

Indicator	Baseline	Target	Achievement
WHO-wide workplans (2004-2005) and proposed programme budget (2006-2007) reflecting technical support and financial resources required to put the country cooperation strategies into practice	Country cooperation strategies not systematically used in 2004-2005 workplans and in 2006-2007 proposed programme budget	Ensure majority of countries use country cooperation strategies in preparation of 2004-2005 workplans and Programme budget 2006-2007	Country cooperation strategies used to inform the development of most country office workplans during the biennium and in the development of the Programme budget 2006-2007
WHO workforce planning exercise at country level, based on the WHO strategic agenda, as expressed in the country cooperation strategy, and its implications for the Organization	WHO workforce planning at country level not aligned with the country cooperation strategy	Alignment of WHO workforce planning at country level when country cooperation strategy available	Most country cooperation strategies are leading to the reprofiling exercise of the country teams. All regions have embarked on implementation

All biennial workplans are derived from the country cooperation strategy and joint planning has started between the three levels of the Organization.

Effective Performance of WHO country teams particularly in relation to national capacity building

Indicator	Baseline	Target	Achievement
Evaluations of WHO performance at country level used for strengthening country teams	Mid-term and end-of-biennium assessments but with gaps remaining for assessing WHO performance at country level	Framework for evaluating WHO performance at country level designed	Interregional/headquarters working group set up in 2005 to design a framework for assessing WHO performance at country level

During the biennium, country performance evaluations were undertaken by the Office of Internal Audit and Oversight in all regions.

Effective administrative, communication and managerial systems for WHO's work in countries

Indicator	Baseline	Target	Achievement
Formally documented delegation of authority and framework of accountability for all countries where WHO has a presence	WHO Representatives reporting insufficient delegation of authority in the third Global Meeting of WHO Representatives and Liaison Officers	Enhanced delegation of authority in all regions	Programmatic and financial delegation of authority to WHO Representatives increased significantly in most regions. A WHO accountability framework available
Analysis of managerial reviews of country offices, particularly those with large operational components	No analysis available	Review conducted in most country offices	Country reviews conducted in 4 regions
Number of country offices able to maintain regular communications with regional offices and headquarters through the WHO Global Private Network and the Internet	4 country offices and 6 regional offices connected to the Global Private Network	Increase in the number of countries with access to the Global Private Network and full coverage for the African Region	The 6 regional offices and 85 country offices connected to the Network. A further 56 country offices in the implementation phase. Videoconferencing facilities available in all 6 regional offices. Most country offices have their own web sites or page on the regional office sites

In the Region of the Americas, formal mid-term assessment and end-of-biennium evaluations were conducted for all country offices and technical programmes, including assessment of managerial aspects. In the African Region, Angola and Nigeria underwent the managerial review exercise in connection with the reprofiling. In the Eastern Mediterranean Region, a country office assessment database was developed and utilized.

Enhanced delegation of authority to WHO Representatives in the Regional Office for South-East Asia included the recruitment of long- and short-term staff in country offices and a US$ 50 000 ceiling for issuing agreements for performance of work. The Regional Office for Europe increased delegation of authority in several country offices, depending on their capacity.

All WHO Representatives were included in the WHO Global Leadership Programme.

Reliable, up-to-date information on health issues available within countries for WHO staff and others involved in contributing to achievement of national health and development goals

Indicator	Baseline	Target	Achievement
Existence of effective documentation centres in WHO country offices, based on well-defined WHO standards and including virtual access to information	Not established	Not established	A substantial majority of country offices have a documentation centre/ library/knowledge-management base based on WHO standards

In the African Region, almost all countries operate "blue trunk libraries". The Global Private Network, which now covers all countries, gives greater virtual access to information. Most country offices in the Region of the Americas have documentation centres and web pages that provide virtual access to information through the Virtual Health Library. In the Eastern Mediterranean Region, all country offices have access to databases and virtual libraries and documentation through the Regional Office Intranet and portal of the Department of programme planning, monitoring and evaluation.

Health aspects of national development, poverty reduction and emergency relief and response strategies supported by clear operational policies on WHO's participation in coordination of development cooperation, such as the Common Country Assessment and United Nations Development Assistance Framework

Indicator	Baseline	Target	Achievement
Existence of WHO guidance on different types of coordination processes and mechanisms for development cooperation at country level	Global Fund to Fight AIDS, Tuberculosis and Malaria 2003 guidance note; United Nations joint programming guidance in 2004; no proposition papers on sector-wide approaches, poverty reduction strategies, Millennium Development Goals, United Nations	Revised WHO guidance note regarding Global Fund processes at country level circulated to regions. WHO position paper on sector-wide approaches developed and circulated to regions	A set of tools and guidelines aimed at improving WHO support to national development strategies and other coordination processes developed in collaboration with other relevant technical units. These include: guidance paper on Global Fund related activities in WHO; WHO harmonization and alignment: key resources; guide to WHO's role in sector-wide approaches to health development
Existence of an interregional and in-country cadre of trained staff supporting active national capacity building for coordination mechanisms and processes related to national and international health	No existing interregional or in-country cadre of trained staff	Capacity building of country office staff initiated in all regions	Country cooperation strategies being used for better alignment of national health priorities and strategies (e.g. poverty reduction strategies) and harmonization with the United Nations and other development partners. WHO actively involved in 71 poverty reduction strategy exercises. 85% of country offices participating in the Common Country Assessment/United Nations Development Assistance Framework (CCA/UNDAF) process

WHO has been fully involved in the United Nations reform process as a member of the United Nations Development Group and is participating in its working groups. The fourth meeting of the country support unit network agreed on a strategy for building capacity of country teams in addressing the harmonization and alignment agenda. The Development Group's information on the CCA/UNDAF process has been widely shared and disseminated through regional offices.

Success factors and impediments

Success factors

- An enabling environment was provided by improved communication and coordination between the three levels of the Organization.
- Clear orientations were laid down in regional guidelines.
- Financial support was provided to the country support unit network.
- Strong commitment existed for country support.

Impediments

- Insufficient funding was available especially for proper shaping of WHO country presence as a key mechanism for strengthening national health systems.
- Slow and insufficiently user-friendly administrative procedures precluded efficient operation.
- Delegation of authority was limited in both technical and administrative areas.
- Performance assessment was weak, as was the accountability framework.

Lessons learnt in 2004-2005 and how they will be applied in 2006-2007

- Political commitment of senior management is required to enhance support for technical cooperation at the country level.
- The country cooperation strategy process brings proper knowledge and understanding of the health needs and priorities of each country; when adopted and operationalized across the Organization, it becomes a powerful tool for collaborating with Member States and key health development partners.
- Ensuring an appropriate level of resources for country presence and capacity building in line with the country cooperation strategies is a good investment. It allows good communication and collaboration with all partners, effective coordination of WHO activities, and brings all WHO levels together.
- Emphasizing the health systems framework in WHO country collaboration provides a powerful platform for sustainable technical advice and helps to bring about a better understanding of the role of other national and international health actors.
- Improved telecommunications enhanced the efficiency of country work.

In 2006-2007, lessons learnt in the previous biennium will be applied especially to:

- advocate for an adequate level of resources for strengthening WHO presence at the country level;
- scale up the country cooperation strategy process;
- enhance communication between regional offices in order to share experiences, lessons learnt and good practices through the development and utilization of the country support unit network portal.

Approved budget and actual expenditure

		Approved budget	Actual expenditure		
			Regular budget	Other sources	All funds
Total 2004-2005 (US$ thousand)		148 630	134 267	27 167	161 434
Percentage	countries	92	96	60	90
	regions	5	2	29	6
	global	3	2	11	4

MISCELLANEOUS

EXCHANGE RATE HEDGING

Purpose In adopting the appropriation resolution for 2002-2003, the Fifty-fourth World Health Assembly also approved a new exchange rate hedging mechanism in lieu of the former exchange rate facility.[1] This new mechanism complies with the provisions of Financial Regulation 4.4 which states that … *The purpose of the facility shall be to make it possible to maintain the level of the budget so that the activities that are represented by the budget approved by the Health Assembly may be carried out irrespective of the effect of any fluctuation of currencies against the United States dollar at the official United Nations exchange rate.* … It is proposed that a similar procedure be followed for 2004-2005 in respect of both the regular budget and that part of other sources represented by the Special Account for Servicing Costs.

Expected results	Indicators and achievement
The regular budget and that part of other sources represented by the Special Account for Servicing Costs so protected from the impact of foreign currency fluctuation that the approved budgeted levels may be implemented either in full or to the maximum extent possible, irrespective of the effects of fluctuations against the United States dollar	*Adequacy of the budget provision to allow for exchange rate hedging such that the implementation of the related programme proposals will not be reduced as a result of adverse fluctuation in exchange rates.* Foreign exchange protection measures resulted in cash flows of US$ 30 million to offset the effect of the weaker dollar on the value of the regular budget.

Hedging gains of US$ 30 million almost bridged the gap between the actual and budget exchange rates.

REAL ESTATE FUND

Purpose The Real Estate Fund was established by the Twenty-third World Health Assembly[2] in order to make funding available to meet the costs of acquisition of land and buildings, major repairs of and alterations to the Organization's office buildings and the maintenance, repair and alteration to selected staff housing. In accordance with the revised Financial Regulations and in order to increase transparency regarding the cost of the Organization's real estate operations, the regular budget now covers funding of the Real Estate Fund which previously had come directly from Miscellaneous Income (formerly Casual Income).

Expected results	Indicators and achievement
Office accommodation, and staff housing where applicable, provided that is cost effective and has an acceptable level of security	*Completion of construction and maintenance work in accordance with the relevant plans and schedules.* Short-term maintenance plans have been met and a strategy to elaborate a 10-year capital master plan was submitted to the 117th session of the Executive Board for approval.[3]

The construction and renovation projects undertaken during this period included an extension to the Regional Office for the Western Pacific and refurbishment of the air-conditioning system in the Regional Office for South-East Asia. Significant repairs were carried out to the heating, ventilation and air-conditioning systems at headquarters and some refurbishment work was undertaken in the regional offices for the Americas and Europe.

INFORMATION TECHNOLOGY FUND

Purpose The Information Technology Fund was established by the Director-General in 2001, in line with Financial Regulation 9.3, to cover the Organization's requirements for a global management system. In accordance with Financial

[1] Resolution WHA54.20, section A.

[2] Resolution WHA23.14.

[3] Document EB117/18.

Regulation 3.2, an amount reflecting the expected contributions from the regular budget is proposed for inclusion in the Information Technology Fund and is reflected in the Proposed programme budget for 2004-2005.

Expected results	Indicators and achievement
Alternative solutions assessed against system requirements that have been formulated in response to user needs and on the basis of streamlined business processes	*Contract awarded on basis of match with requirements.* Two primary contracts were awarded which meet the requirements established for each. One, for commercial software for the global management system, will allow all WHO staff to use the system and price protection is guaranteed to 2013. The second, for implementation, covers the life cycle of the project up to and including worldwide deployment of the system. *Number of customized features put in place based on identified needs.* In the global management system emphasis is placed on streamlining and harmonizing processes throughout WHO in order to minimize customization. The extent to which customization will be required will be determined in 2006.
A detailed plan to implement the chosen solution(s) established and followed with clearly delineated roles, responsibilities and schedules	*Passing successive project milestones.* Successive milestones have been passed in establishing the project structure, governance, team and project plan; mapping existing processes and elaborating the future direction; and establishing contracts with the commercial software vendor and implementing partner.

The project is intended to facilitate managerial reform and improve administrative efficiency. The future direction, key performance indicators and expected changes have been elaborated, the project and governance structure has been established and the project team engaged. The structure includes a project board and users' committee, as well as regional participation to meet the functional and technical needs of all levels of the Organization. A project plan has been elaborated, the existing processes have been mapped and work has commenced on the definition phase of the project. The contract for acquisition of commercial software was awarded after a thorough process of comparison, review and negotiation. Although this process took longer than planned, the resulting contract had a flexible enterprise-wide licensing structure allowing worldwide use and guaranteed price protection until 2013. An initial exercise was conducted to identify possible gaps where the software may not meet future requirements. Negotiations with an implementing partner resulted in a fixed-price contract that will accommodate the Organization's needs for the life cycle of the project up to and including worldwide deployment of the system.

SECURITY FUND

Purpose In line with Financial Regulation 9.3 the Security Fund was set up by the Director-General for financing in 2002-2003 WHO's share of the costs of the United Nations system's security arrangements at field locations. In pursuance of the concept of a gross budget, as foreseen in Financial Regulation 3.2, this item has been included in the proposed programme budget for 2004-2005.

Expected results	Indicators and achievement
Reliable systems within WHO in place for monitoring security issues in all locations where personnel operate	*Timeliness of response to security incidents.* The ability to respond improved as a result of strengthened staff security at headquarters and in most regions. However providing the appropriate response is still hampered by failure to report incidents when they occur.
Increased numbers of WHO staff trained in United Nations security management system and personal security	*Degree of compliance with security procedures at country level.* At country level, WHO Representatives and their staff are still not fully compliant with security procedures. In 2006-2007, a greater effort will be made to better inform Representatives through regional meetings and country visits. The introduction of an accountability framework is expected to lead to improvements.

Expected results	Indicators and achievement
Effective support provided to ensure that WHO meets the minimum operating security standards, set by the United Nations Security Coordinator, in all of its country offices	*Degree of compliance with minimum operating security standards.* A lack of resources hampers compliance. A survey to be conducted in 2006-2007 will identify needs and the resources required.

WHO made a contribution of US$ 6.6 million to the United Nations department of safety and security for field-related security costs, participation in the United Nations security management system, and support to training projects and policy development. Several training courses were organized at headquarters, and at regional and country level. The processing of security clearances was streamlined at headquarters and WHO collaborated with the United Nations department of safety and security to develop a system to improve efficiency at all levels. Priority was given to the security of teams being deployed to or operating in the field, security assessment missions, and the management of stand-by security capacity.

EXCHANGE RATE HEDGING

Approved programme budget versus expenditure (US$ thousand)

Approved programme budget	Actual expenditure
20 000	14 550

REAL ESTATE FUND

Approved programme budget versus expenditure (US$ thousand)

Approved programme budget	Actual expenditure
6 000	11 851

INFORMATION TECHNOLOGY FUND

Approved programme budget versus expenditure (US$ thousand)

Approved programme budget	Actual expenditure
35 000	41 943

SECURITY FUND

Approved programme budget versus expenditure (US$ thousand)

Approved programme budget	Actual expenditure
9 000	19 215