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Proposed programme budget 2006–2007

The attached draft of WHO's proposed programme budget for 2006–2007 is submitted to the Regional Committee for its review and comments before it is presented to the Executive Board at its 115th session in January 2005 and subsequently to the Fifty-eighth World Health Assembly in May 2005. It should be read in conjunction with the document on the European Region's perspective (EUR/RC54/11 Add 1).

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WORLD HEALTH ORGANIZATION

PROPOSED PROGRAMME BUDGET

2006–2007

CONTENTS

I. INTRODUCTION

1. WHO's Proposed programme budget 2006-2007 is the fourth successive biennial budget that follows an Organization-wide results-based approach. The programme formulation revolves around a set of objectives, strategies, and Organization-wide expected results. These expected results – outcomes to which the WHO Secretariat collectively (country offices, regional offices, and headquarters) – is committed over the biennium, form the basis for costing and estimating resource requirements. They also justify resource allocation. Actual achievements in implementing the programme budget are measured through performance indicators.

2. The Proposed programme budget was drawn up through a participatory and iterative process, involving dialogue between countries, regional offices and headquarters. An internal peer review of a preliminary draft, involving all levels of the Organization, took place in March 2004. For the first time, lessons learnt in implementing the previous biennial programme, as captured in the performance assessment report for the biennium 2002-2003, constituted an important input in the process.[1]

3. Submission of the draft Proposed programme budget to the regional committees is an important step in the consultative process. Comments from Member States at the regional committees will help to refine the document in the light of regional perspectives. The Director-General will submit it to the Executive Board for review at its 115th session, and then to the Fifty-eighth World Health Assembly.

Strategic direction

4. The Proposed programme budget 2006-2007 both clearly continues WHO's work during the last biennium, building on achievements and lessons learnt, and sets out current and emerging priorities, reflected in resolutions of recent Health Assemblies. Greater attention given internationally to the challenges faced by global public health have substantially increased demands on, and expectations from, WHO. Global health security has been recently threatened by outbreaks of SARS and avian influenza, raising the spectre of global pandemics on a scale not witnessed for nearly a century. New mechanisms such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and crucial developmental processes such as Poverty Reduction Strategy Papers require WHO's full commitment. The interrelationship between health and development is now clearly recognized and the importance of focusing on achievement of Millennium Development Goals well accepted. These developments are all encouraging and positive, but they also imply that WHO must expand its resource base in order to fulfill its mandate and fully meet the expectations of Member States.

5. It is proposed to intensify WHO's activities in the following directions:

- **enhancing global health security:** maintaining a comprehensive outbreak alert and response mechanism (resolutions WHA56.29 and WHA54.14), supported by the international health regulations (resolution WHA56.28); responding rapidly and effectively in crisis situations (resolutions WHA57.3 and WHA55.13);

- **accelerating progress towards achieving the Millennium Development Goals:** reducing maternal mortality (resolution WHA57.12), improving child survival (resolutions WHA56.20 and WHA56.21); addressing the global pandemics of HIV/AIDS, tuberculosis and malaria (resolutions WHA57.14, and WHA53.1); promoting healthy environments (resolutions WHA57.9 and WHA57.10); increasing access to essential medicines (resolutions WHA56.27 and WHA55.14);

- **responding to the increasing burden of noncommunicable disease:** reducing tobacco use (resolution WHA56.1), promoting healthy diets and physical activity (resolution WHA57.17), enhancing health-promotion activities (resolution WHA57.16);

[1] Programme budget 2002-2003. Performance assessment report. Document WHO/PRP/04.1 (draft).

- **promoting equity in health:** strengthening health systems to reach poor and disadvantaged people (resolutions WHA57.19 and WHA56.25);

- **ensuring accountability:** improving organizational effectiveness, transparency and accountability.

6. In order to achieve significantly enhanced results in the above directions, priority will be given to the corresponding areas of work, identified below.

Epidemic alert and response. The outbreaks of SARS and avian influenza clearly show the importance of global surveillance and the crucial role WHO is playing in collecting information, coordinating international response, setting international standards and providing support to countries for surveillance and effective response to the threat of disease. WHO is now expected to expand its role and its ability to respond.

Making pregnancy safer. Reducing maternal deaths is one of the key Millennium Development Goals: little progress has been achieved in this area over past decades. Half a million women die each year from pregnancy-related complications; they die not from disease, but from lack of skilled attendants and insufficient emergency obstetric care. Safe motherhood is not only a health issue but also a social and moral one. WHO will lay emphasis on strengthening health systems and activities at country level that will contribute to reducing maternal deaths.

Child and adolescent health. Every year about 11 million children still die from the effects of disease and inadequate nutrition. Seven out of 10 child deaths in developing countries are attributable to five preventable communicable diseases, compounded by malnutrition. The interventions needed to save millions of children's lives are known; WHO will give priority to scaling up its response in order to improve child health in countries.

Surveillance, prevention and management of chronic, noncommunicable diseases and control of tobacco. Noncommunicable diseases represent a growing challenge to health systems, and coupled with communicable diseases constitute a double burden of disease in many developing countries. According to current estimates, chronic, noncommunicable diseases constitute about 40% of deaths in developing countries and almost 75% in developed countries. WHO will lay more emphasis on building systems that can cope with this challenge.

Planning, resource coordination and oversight. A major effort will focus on further improving planning, resource coordination, performance monitoring, assessment, evaluation and oversight in order to improve transparency and programmatic, as well as financial, accountability.

7. Further, in pursuing the work of previous bienniums, the Proposed programme budget 2006-2007 recognizes that health-for-all commitments and the principles and practices of primary health care remain valid goals for the Organization. WHO stands committed to the goal of assuring access to the highest attainable standards of health for all. It seeks better health and access to health care for poor and disadvantaged people, especially women and children. Efforts to tackle HIV/AIDS, particularly through access to treatment as expressed by the **"3 by 5" initiative**, and to strengthen work in the areas of **malaria** and **tuberculosis**, which are top priorities for the biennium 2004-2005, will continue. Emphasis is also laid on maintaining WHO's work and role in strengthening national **health systems**, recognizing that a well functioning, effective health system is essential for the delivery of health care.

8. In some areas, however, efforts are being scaled down. For example, success in eradicating poliomyelitis, expected in 2005, will reduce resources required for this activity, although coverage will continue to be expanded for other vaccine-preventable diseases. Thus, activities in the area of **Immunization and vaccine development** will be maintained, but at a slightly lower level.

9. Some of the priorities of the Proposed programme budget are cross-cutting and Organization-wide. For example, through its focus on decentralization and **results in countries**, the Organization is committed to working more intensively with national health partners in order to meet their priority goals and to move appropriate human, and adequate financial, resources to country level.

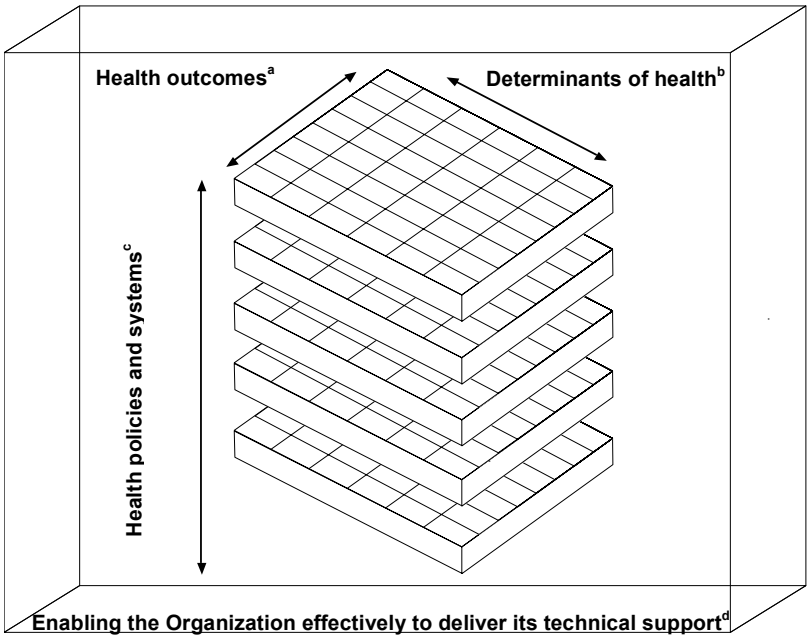
10. In order to achieve the commitments and results expected from increased **organizational efficiency** that started in the biennium 2004-2005, further investments will be made in better management of both human and financial resources. The new Global Management System will be launched in 2006.

Areas of work – the building blocks of the Proposed programme budget

11. The Proposed programme budget is organized around the areas of work set out in Section II, which represent WHO's main orientations. They have been revised through consultation at all levels of the Organization in order to reflect more accurately the work of WHO in countries and to incorporate the strategic directions determined by the Director-General. With well-defined scope and contents, the areas of work are complementary and mutually supportive. The linkages between them are outlined in Figure 1 overleaf.

12. In order to provide greater transparency and accountability, the areas of work contain additional information compared to the previous bienniums. A baseline and targets are provided for each Organization-wide expected result, in addition to resource requirements.

Figure 1. Linkage between areas of work



WHO 04.89

Related areas of work

[a] HIV/AIDS; Child and adolescent health; Communicable disease prevention and control; Surveillance, prevention and management of chronic, noncommunicable diseases; Making pregnancy safer; Malaria; Mental health and substance abuse; Reproductive health; Tuberculosis; Emergency preparedness and response; Epidemic alert and response; Immunization and vaccine development

[b] Food safety; Gender equality, women and health; Health and environment; Health promotion; Nutrition; Tobacco; Violence, injuries and disabilities; Communicable disease research

[c] Health financing and social protection; Health information, evidence and research policy; Essential health technolgies; Health systems policies and service delivery; Human resources for health; Policy making for health in development; Essential medicines

[d] Planning, resource coordination and oversight; Knowledge management and information technology; Budget and financial management; Human resources management in WHO; Infrastructure and logistics; WHO's core presence in countries; Direction; External relations; Governing bodies

Overall level of the budget

13. The increase in the overall level of the budget stems from growing demands made on the Organization. Progress made in achieving results expected in the biennium 2002-2003 is being reported on to Member States in terms not only of financial, but also of programmatic, results.[1] Actual achievements for each area of work during the past biennium provided a sound basis for assessing future requirements. This exercise helped to determine results expected in the biennium 2006-2007, which respond to increased requirements and thus need a higher level of financial resources in order to meet the expectations of Member States and partners. At the same time, opportunities have been seized to use the financial resources of the Organization more efficiently, thus contributing to cost-effective results.

14. In order fully to deliver the Organization's programme and achieve the results expected, the Director-General is proposing an increase in the budget of US$ 361 million for 2006-2007, i.e. a growth of 12.8% compared with the previous biennium. This proposed increase is based on conservative and careful strategic planning throughout the Organization, set within the established results-based framework.

15. Referring to Figure 1, resources required in the areas of work supporting "Health outcomes" are approximately 51% of the total. Comparable figures for "Determinants of health" are 11%; "Health policies and systems", 13%; and "Enabling the Organization effectively to deliver its technical support to Member States", 22%. A further 2% is allocated to exchange rate hedging, and to the information technology, real estate, and security funds.

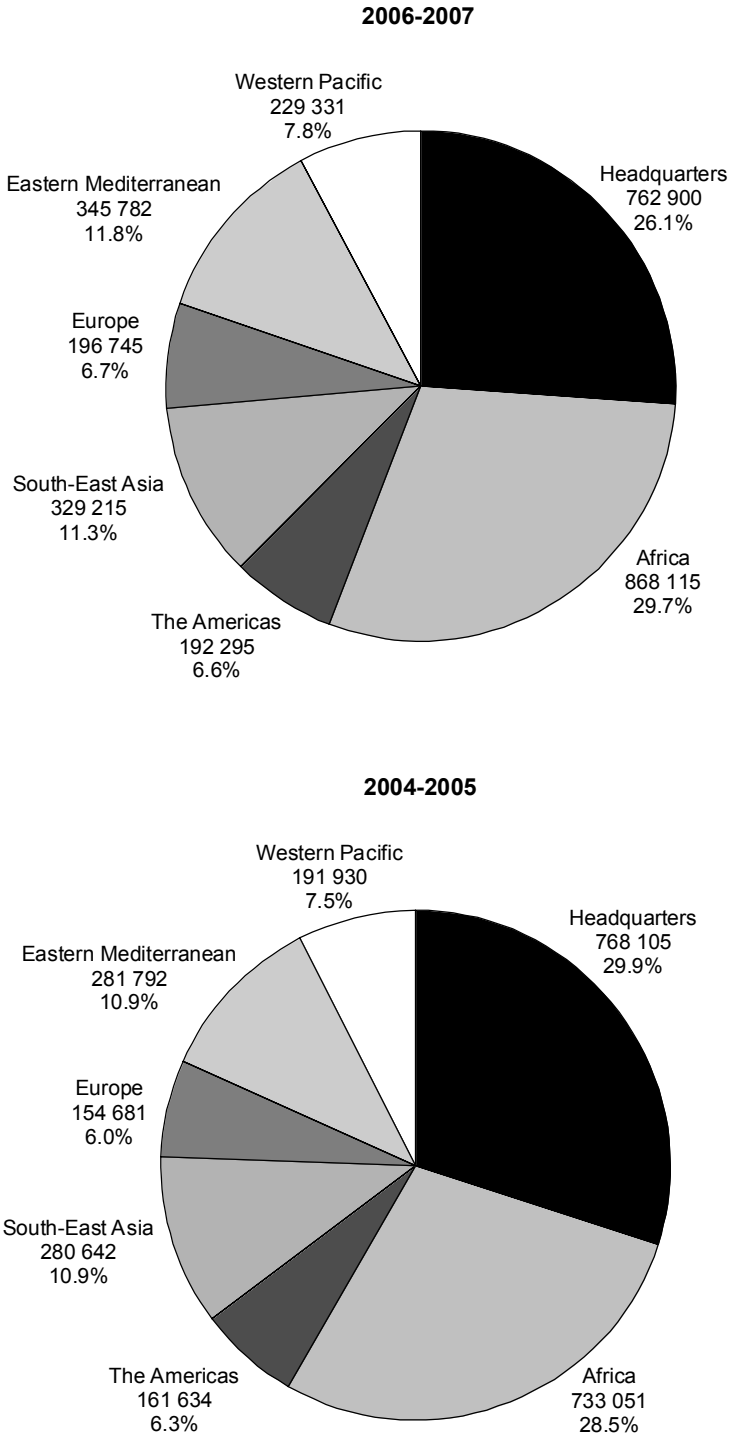
16. The proposed increase will enable the Organization significantly to improve results expected in regions and countries in the five areas of work identified for intensified action (increases of 40% to 60% compared with the biennium 2004-2005), and contribute towards offsetting the effect of inflation. Most importantly, it will allow the Organization to respond to higher expectations in countries in respect of responding to epidemic alerts, achieving the Millennium Development Goals, working with countries on Poverty Reduction Strategy Papers, and building up partnerships with the Global Fund to Fight AIDS, Tuberculosis and Malaria, and others.

17. Figure 2 below provides a breakdown of all the sources of financing between the regions and headquarters for the periods 2004-2005 and 2006-2007. The figures for the regional level combine the proposed amounts for the country and regional budget of the respective region. These figures do not include individual funds and special programmes. The allocations suggested are based on Organization-wide results-based budgeting. The allocation of resources between levels of the Organization is 73.9% in regional and country offices and 26.1% in headquarters. Across the regions allocation is designed to achieve a more equitable distribution of resources and to reach countries in most need.

[1] Document WHO/PRP/04.1 (draft).

Figure 2. Proposed programme budget 2006-2007 compared with programme budget 2004-2005 (resolution WHA56.32), all sources of financing

Summary by regional office (US$ thousand and percentage)



Financing the Proposed programme budget

18. Setting clear priorities, strengthening the work of WHO in countries, regions and globally, and increasing organizational efficiency brings the Organization close to its objectives. Securing the volume of resources that adequately reflect the work of the Organization, its core functions and priorities ensures that it fully meets them.

19. WHO's budget is financed from two principle sources: assessed contributions and Miscellaneous Income, which finance the regular budget, and voluntary contributions (formerly known as extrabudgetary resources). The relationship between these sources has changed significantly over the past few bienniums. The level of the regular budget has increased minimally over the past 10 years, whereas the volume of voluntary contributions has risen substantially. Voluntary contributions now represent some 70% of the total financial resources of the Organization.

20. During this period of growth of voluntary contributions, the overall approach to the budget did not fully reflect an integrated managerial and planning framework as is currently in use in the Organization. As the use of a significant proportion of voluntary contributions is specified, the priorities established by the Health Assembly in the Programme budget can be distorted if some areas of work receive additional finance during the biennium, and others receive less than estimated to meet the expected results. This may lead to questions of coherence and governance.

21. Presentation of a total, integrated proposed budget that includes targets for voluntary contributions strengthens the overall governance and priority-setting of the Health Assembly. An increase in the assessed contributions that is closer to the overall increase in the budget is proposed in order to achieve a better balance between the two sources of funding. It breaks down into 9% in assessed contributions and 14.9% in voluntary contributions, as shown below.

Programme budget – all sources of financing
(US$ thousand)

Source of financing	2004-2005	2006-2007	% change
Assessed contributions	858 475	935 738	9.0
Miscellaneous Income (excluding adjustment mechanism)	21 636	15 345	-29.0
Voluntary contributions	1 944 000	2 234 021	14.9
Total all sources of financing	2 824 111	3 185 104	12.8

Assessed contributions and Miscellaneous Income

22. The amount of Miscellaneous Income estimated for the biennium 2006-2007 reflects a conservative approach that aims to reduce the risk of a shortfall in the amount actually realized. As provided for in the Financial Regulations, in the event of a shortfall in the level of Miscellaneous Income the Director-General is required to reduce implementation of the budget, an outcome that should be avoided.

23. In the biennium 2004-2005 the total amount of Miscellaneous Income forecast was US$ 34 million. It was decided in resolution WHA56.32 to use an amount of US$ 12 million to finance the adjustment mechanism which compensates Member States that would experience an increase in their rates of assessment for 2004-2005 compared with 2000-2001. The net amount of Miscellaneous Income in 2004-2005 applied in financing the regular budget was therefore US$ 22 million. In accordance with resolution WHA56.34, it is expected that the adjustment mechanism will be maintained in 2006-2007; an amount of US$ 8.6 million is envisaged for appropriation from Miscellaneous Income by the Fifty-eighth World Health Assembly. The Miscellaneous Income forecast for 2006-2007 of US$ 24 million has been adjusted accordingly, giving a total of US$ 15 million.

24. The level of the budget 2006-2007 to be financed by assessed contributions and Miscellaneous Income is proposed at US$ 951 million. The net amount to be paid as assessed contributions by Member States is US$ 935 million. This level represents an increase of US$ 71 million or 9% compared with assessed contributions for 2004-2005.

25. In accordance with Financial Regulation VII, it is proposed that the Working Capital Fund which, together with internal borrowing, is used to finance cash-flow deficits that arise from late payment of assessed contributions, should be maintained at US$ 31 million.

Voluntary contributions

26. Voluntary contributions include funds provided by Member States and other partners that are used for that portion of the integrated budget which is not financed by assessed contributions. The level of voluntary contributions required for the biennium 2006-2007 is US$ 2234 million. This represents an increase of US$ 290 million or 14.9% compared with 2004-2005.

27. The increase in voluntary contributions will be realized through strategic partnerships and a focused resource-mobilization strategy that reflects the priorities of the Organization. These efforts will be an integral part of a resource-allocation strategy that directly aligns the use of resources with achievement of expected results.

28. A portion of these contributions, known as programme support costs, is used to finance the administrative support services that underpin effective achievement of the results expected in all areas of work. In keeping with the authority given to the Director-General in both the Financial Regulations and Health Assembly resolutions, 13% of this income will be used to meet costs in the following areas of work: Knowledge management and information technology, Planning, resource coordination and oversight, Human resources management in WHO, Budget and financial management, Infrastructure and logistics, Governing bodies, External relations, and Direction.

Management of exchange-rate risk

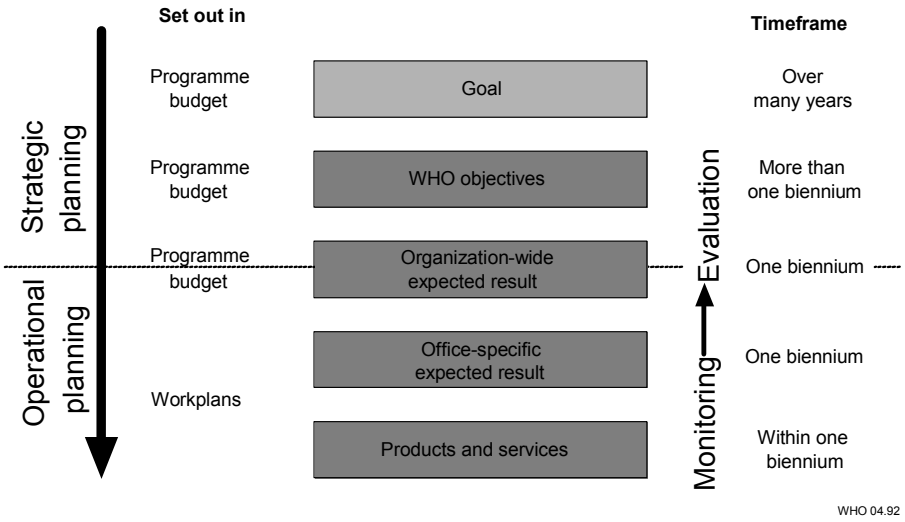
29. As in previous bienniums it is necessary to protect the budget so that the expected results may be achieved irrespective of the effect of fluctuations of currencies compared with the United States dollar, the base currency of the Organization. The resources required to meet the results expected for 2006-2007 have been determined on the basis of a historic exchange rate.[1] This rate of exchange will be protected through a foreign-exchange risk strategy drawn up in the light of market conditions in mid-2005. At the time of writing, it is envisaged that an amount of US$ 15 million will be made available to protect, to the extent possible, the assessed contribution portion of the budget from the impact of exchange rate fluctuations. It is expected that a further amount of US$ 5 million will be set aside in respect of the portion of the budget financed by programme support costs. The level of those parts of the budget that are thus protected will be adjusted during the biennium in order to reflect the effect of changing exchange rates.

Implementing the Proposed programme budget

30. The Proposed programme budget is WHO's strategic plan for the biennium 2006-2007, providing common objectives for WHO's work. It is implemented through operational plans prepared by country and regional offices and headquarters (see Figure 3).

[1] These requirements will be recosted at the exchange rate prevailing at the time of submission of the Proposed programme budget to the Fifty-eighth Health Assembly.

Figure 3. Implementing the Proposed programme budget



31. Country and regional offices and headquarters define the results to be achieved at the end of the biennium (office-specific expected results), and draw up their work plan on the basis of products needed to achieve those results. The office-specific expected results are country focused. While meeting the specific needs of countries, the results are derived from, and support, achievement of the Organization-wide expected results set out in the Proposed programme budget. Through its integrated approach to financing of the budget, the Organization will use the resource requirements estimated for each expected result as the basis for mobilizing, prioritizing, and allocating funds across areas of work and by Organizational level. Gaps between resources required to execute the Proposed programme budget and availability of resources for implementation of areas of work by countries, regions and headquarters will be continuously monitored. To the extent possible, the actual allocation of resources across areas of work will be adjusted and the necessary shifting of resources undertaken throughout the biennium in an attempt to close the gaps, ensuring that the resources are available to achieve results in the right place and at the right time.

II. ORIENTATIONS 2006-2007 BY AREA OF WORK

COMMUNICABLE DISEASE PREVENTION AND CONTROL

ISSUES AND CHALLENGES

Diseases covered by this area of work for intensified control include Buruli ulcer, dengue/dengue haemorrhagic fever, intestinal parasitoses, leishmaniasis, schistosomiasis, trachoma, trypanosomiasis, zoonoses, and epidemic enteric diseases. Dracunculiasis is targeted for eradication. The goal for leprosy, lymphatic filariasis, onchocerciasis and Chagas disease is elimination at global or regional level.

These diseases affect almost exclusively poor and powerless people living in rural parts of low-income countries. They cause immense suffering and often life-long disabilities, but rarely kill, and therefore remain low on countries' public-health agendas and do not receive the level of attention afforded to high-mortality diseases.

For most of these diseases, effective, safe and economical interventions are available. In the absence of a demand by disease-endemic countries for greater attention to be paid to these diseases, however, global resources remain scarce and progress toward their control, prevention and eradication or elimination is unacceptably slow.

A major challenge is to increase access to drugs and interventions for targeted diseases while reinforcing health systems through innovative approaches within the framework of countries' priorities and strategic plans. Such approaches could include, for instance, use of the school system. A particular challenge is to develop new tools, including drugs, vaccines and diagnostic tests, and cost-effective strategies for those communicable diseases for which such instruments are still lacking, especially in countries facing complex emergencies. Further alliances of partners should be facilitated in order to work in synergy at global, regional and national levels to deal with neglected diseases; the strong link with poverty and human rights needs to be highlighted and advantage taken of lessons learnt through the implementation of concrete actions against neglected diseases. Lastly, intense advocacy is needed to increase both commitment and resources from the international community, and political commitment within affected countries in order to extend interventions for the intensified control of neglected diseases.

GOAL

To reduce the negative impact of communicable diseases on health and on the social and economic well-being of all people worldwide.

WHO OBJECTIVES

To reduce morbidity, mortality and disability through the prevention, control and, where appropriate, eradication or elimination of selected communicable diseases using, where possible, a synergetic approach.

Indicators

- Number of countries with active national programmes targeting neglected communicable diseases
- Number of countries progressing towards targets set by specific Health Assembly resolutions for the targeted diseases

STRATEGIC APPROACHES

Formulation and implementation of evidence-based strategies; provision of technical support to countries; capacity building; and involvement of relevant partners for implementation, including in countries facing complex emergencies; formulation of integrated disease-control strategies, including integrated case management, vector control and interventions through schools.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Comprehensive guidance formulated and available for development of policies and strategies for the prevention, control and elimination of neglected communicable diseases that will be effective in reaching populations at risk.	• Number of national and subnational strategic plans developed or revised on the basis of WHO guidelines for the prevention, control and elimination of selected communicable diseases affecting populations at risk	50	100
2. Effective approaches to the prevention, case management, surveillance and control of neglected communicable diseases in low-resource settings validated and promoted in priority countries.	• Number of low-resource countries where guidelines and training materials on integrated management of adolescent and adult illness for first-level facilities and district hospitals are adapted for country use	20	60
	• Number of countries adapting and implementing integrated school-health interventions	80	105
	• Number of countries where effective approaches for the surveillance, prevention and control of emerging enteric diseases have been established	30	80
3. Innovative partnerships and coordination mechanism mobilized to strengthen effectively the capacity and role of health ministries for the control of targeted communicable diseases.	• Number of countries that have built effective partnerships, including with nongovernmental organizations, private providers, civil society and international organizations, for control of targeted communicable diseases with WHO's support	80	105
	• Number of countries where intersectoral collaboration for zoonotic and food-borne diseases have been effectively put in place with WHO's support	50	100
4. Priority countries adequately supported to adopt and implement policies and strategies, including countries facing complex emergencies.	• Number of countries facing complex emergencies provided with effective support for applying appropriate components of prevention and control of communicable diseases	8	10
	• Number of targeted countries implementing synergetic intensified control of neglected diseases with WHO's support	10	20
5. Innovative and cost-effective interventions, techniques and tools devised and validated for implementation of prevention, control and elimination of communicable diseases in low-resource settings, including in complex emergencies.	• Number of new integrated case-management strategies for control of neglected communicable diseases	-	5
	• Number of new techniques and tools developed and tested for the surveillance, prevention and control of zoonotic, and water- and food-borne diseases	-	2
6. Adequate support provided to countries for strengthening capacity for achieving substantial progress in the intensified control or elimination of targeted communicable diseases.	• Number of countries that have completed disease mapping and started mass drug administration for lymphatic filariasis	46	55
	• Number of countries that have updated national programmes for the prevention and control for major zoonoses or food-borne disease with WHO's support	50	80

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				154 056	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

Communicable disease prevention and control is also supported by results expected to be achieved in other areas of work, as set out below.

Area of work	Expected result(s)

COMMUNICABLE DISEASE RESEARCH

ISSUES AND CHALLENGES

Despite the continued resources and efforts put into their prevention, infectious diseases persist and contribute a major part of the disease burden in developing countries. They continue to impede social and economic development and disproportionately to affect poor and marginalized populations; they will therefore be major hindrances to attaining the health-related Millennium Development Goals. Effective tools have long been lacking for the control of some diseases. For others, tools, methods and strategies once considered sufficient for successful prevention and control are now failing: microorganisms have developed resistance to drugs; insect vectors have developed resistance to pesticides; ecological and social conditions change; or ensuring their sustainable implementation becomes difficult. Absence of commercial incentive and lack of appropriately directed research resources limit the engagement of both the private and the public sectors. As a result, there is no innovation or inadequate evaluation and implementation of new tools; many potentially valuable tools and methodologies have yet to be properly evaluated. Experience shows, however, that the public and private sectors and networks of researchers can, through appropriate mechanisms, cooperate efficiently to overcome many of these obstacles: the experience of the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases is a case in point.

Numerous challenges remain. The biosocial, economic and political determinants of the persistence of the burden of communicable diseases need to be better understood. New knowledge being generated through modern science, such as genomics, has to be translated into development of new products (drugs, vaccines and diagnostic tools) that are acceptable, affordable and applicable to the circumstances that prevail in developing countries. Appropriate evidence needs to be generated in order to facilitate the work of countries in defining how best to use these products and new methodologies and to evaluate their use for assessment of implications for policy. A further challenge is to identify mechanisms for expanding those methodologies that are worthy of inclusion in policy. Capacity needs to be built and appropriately used in developing countries so that advances in knowledge and technology can be assimilated and applied in a sustainable manner. Finally, awareness needs to be raised among resource contributors and development partners of the need for and role of health research to achieve health-related Millennium Development Goals and to mobilize the resources required.

Success in all these endeavours requires building broad partnerships for research and product development, involving health systems, control programmes, industry, researchers and donors from both developing and developed countries.

GOAL

To foster research activities, to generate knowledge, and to create essential tools for preventing and controlling neglected infectious diseases.

WHO OBJECTIVES

To improve and develop tools and approaches which are applicable by developing countries for preventing, diagnosing, treating and controlling neglected infectious diseases, and to strengthen the capacity of disease-endemic countries to undertake the research required for developing and implementing new and improved disease-control approaches.

Indicators

- Accessibility to new and/or improved approaches for preventing, diagnosing, treating and controlling neglected infectious diseases in developing countries where they are endemic
- Extent of input of disease-endemic countries to communicable-disease research

STRATEGIC APPROACHES

Strategic research directions based on sound and validated analysis and prioritization of the most critical areas of research on specific diseases and, where appropriate, multiple diseases; balancing of a portfolio between long-term, high-risk projects and shorter-term, low-risk projects, and the basis of innovation; organization, funding and management of research activities, combining functional areas of expertise with a disease focus and control needs; activities with defined milestones and criteria for success, and based on focused research questions, issues and objectives, that are undertaken in partnership (with academic scientists, pharmaceutical companies and disease-control experts); knowledge management, partnership building, and networking with disease-control and research communities in disease-endemic countries for strengthening research capacity, setting priorities and identifying solutions; particular emphasis on extending research so that it better links to, and integrates with, disease control and can aid programme and policy implementation.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. New basic knowledge about determinants (biomedical, social, economic, health systems, behavioural and gender) and other factors of importance for prevention and control of infectious diseases, generated and accessible.	• Number of new, significant and relevant scientific advances in the biomedical, social, economic and public-health sciences	0	250
2. New and improved tools, including drugs, vaccines and diagnostic tools, devised for prevention and control of infectious diseases.	• Number of new and improved tools, such as drugs and vaccines, receiving regulatory approval and/or label extensions or, in the case of diagnostic tools, being recommended for use in controlling neglected tropical diseases	0	5
	• Number of new and improved epidemiological and environmental tools recommended for use in controlling neglected tropical diseases	0	2
3. New and improved intervention methods for applying existing and new tools at clinical and population levels developed and validated.	• Number of new and improved intervention methods validated for prevention, diagnosis, treatment or rehabilitation, for populations exposed to or affected by infectious diseases	0	4
4. 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.	• Number of new and improved policies and strategies for enhanced access to proven public health interventions formulated, validated and recommended for use	0	6
5. Partnerships established and adequate support provided for strengthening capacity for research, product development and application in disease-endemic countries.	• Number of research institutions in low-income disease-endemic countries strengthened	0	3
	• Proportion of new and significant scientific advances produced by scientists from disease-endemic countries	56%	60%
6. Technical information and research guidelines accessible to partners and users.	• Number of research instruments and guidelines for infectious diseases developed and published	0	15
	• Number of global research priority-setting reports for neglected infectious diseases published	0	4

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				109 672	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

Communicable disease research is also supported by results expected to be achieved in other areas of work, as set out below.

Area of work	Expected result(s)

EPIDEMIC ALERT AND RESPONSE

ISSUES AND CHALLENGES

Global health security (as referred to in resolution WHA54.14) is repeatedly threatened by the emergence of new or newly recognized pathogens, their possible deliberate or accidental release, and the resurgence of known epidemic threats. Although biological weapons represent the most visible threat to security, emerging or epidemic-prone communicable diseases (such as influenza, meningitis, severe acute respiratory syndrome, cholera or Ebola virus haemorrhagic fever) also threaten global health security because they frequently and unexpectedly challenge national health services and disrupt routine control programmes, diverting attention and funds.

Most outbreaks and epidemics are caused by known pathogens, but new infectious diseases continue to emerge, many of which appear to originate as zoonoses. Outbreaks and epidemics do not recognize national boundaries and, if not contained, can rapidly spread internationally. Unverified and inaccurate information on disease outbreaks often elicits excessive reactions from the media and authorities, leading to panic and inappropriate responses, which in turn may result in significant interruptions of trade, travel and tourism, thereby placing further economic burden on affected countries. Reliable and rapid laboratory diagnostic support is a prerequisite for effective and prompt response. At present many outbreaks remain undiagnosed. Inability to diagnose infections during the early phase of disease outbreaks leads to greater morbidity and mortality, which could have been averted.

Preparedness is crucial for improving global health security. National surveillance and response systems should provide ongoing surveillance of major diseases, and also function effectively to provide information for alert and response to outbreaks (whether natural, deliberate or accidental). To be sustainable, such systems should be integrated into national communicable disease surveillance, within the health information system.

The revised International Health Regulations provide a powerful tool for harmonizing public health action among Member States and a framework for notification, identification and response to public-health emergencies of international concern.

Despite considerable progress recently, major challenges for the biennium include the need for strengthened global partnership, advocacy and improved international cooperation to deal with epidemics and emerging-disease threats. Further, it is vital to update and implement national, regional and global surveillance and containment strategies for known epidemic diseases and to exploit new tools and knowledge. Mechanisms need to be reinforced to detect, verify and respond rapidly and effectively to unexpected outbreaks and epidemics at local, national, regional and international levels. National plans of action for epidemic alert and response need to be developed, implemented and evaluated within national communicable disease surveillance systems, and, as far as possible, using a multidisease approach. Finally, the revised International Health Regulations need to be implemented in order to provide a regulatory framework for global health security.

GOAL

To ensure global health security and foster action to reduce the impact of communicable diseases epidemics on health and the social and economic well-being of all people worldwide.

WHO OBJECTIVES

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 or unknown etiology, and to integrate these activities with the strengthening of communicable disease surveillance and response systems, national health information systems, and public health programmes and services.

Indicator

- Timely detection of and response to epidemics and emerging-disease threats of national and international concern

STRATEGIC APPROACHES Sustaining of national and international interest and commitment for epidemic alert and response; support for policy and strategy formulation at regional and national levels for epidemic alert and response in accordance with the global strategy; reinforcing of WHO's unique role in leadership and coordination by refining the Global Outbreak Alert and Response Network; strengthening of national early warning, surveillance and response systems through improved laboratory capacity (including training), operational research and training in field epidemiology; setting up of appropriate mechanisms to implement the revised International Health Regulations.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Effective partnerships formed at national, regional and global levels, national interest and commitment raised and adequate resources mobilized to support epidemic alert and response.	• Number of new partnership initiatives at regional and global levels providing financial, political or technical support to epidemic alert and response, or involving new sectors (e.g. animal health, agriculture and security), or both	0	5 new global partners in financial support; 3 regional initiatives on epidemic alert and response; 3 global partnerships in new sectors
2. Strategy for detecting and responding to epidemics and guidance on best ways to provide support to countries updated in close collaboration with WHO collaborating centres and international partners.	• Number of new or updated plans for implementation of updated strategy and delivery of supporting materials for epidemic readiness and intervention available in official and other relevant languages	0	6 (1 per region)
	• Proportion of low- and middle-income countries implementing WHO strategies for strengthening surveillance of targeted major epidemic-prone diseases and enhancing readiness for response	40%	60%
3. Appropriate alert and response to public health emergencies of international concern coordinated through collaboration between all Member States, WHO collaborating centres, and partners in the Global Outbreak Alert and Response Network.	• Proportion of reported outbreaks that were verified	70%	80%
	• Proportion of requests for assistance to which response was provided	95%	100%
	• Number of new technical areas (e.g. anthropology, infection control) for which WHO has established cooperation with institutions for outbreak control	0	3
4. Adequate support provided to Member States for strengthening national communicable disease surveillance and response systems, including the capability for early detection, investigation of, and response to, epidemics and emerging infectious disease threats, according to guidelines of the International Health Regulations.	• Proportion of low- and middle-income countries supported in their implementation of national surveillance plans, including preparedness plans, early warning, communications, laboratory capacity, field epidemiology and public health mapping	40%	60%

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
5. Procedures established for the administration of the revised International Health Regulations and Member States supported for the implementation of the revised Regulations.	• Proportion of countries starting to assure required core capacities needed to comply with the International Health Regulations	0	80%

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				130 944	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

Epidemic alert and response is also supported by results expected to be achieved in other areas of work, as set out below.

Area of work	Expected result(s)

MALARIA

ISSUES AND CHALLENGES

Malaria causes annually about 300 million cases of acute illness, of which more than a million are fatal, and contributes to the gap in prosperity between disease-endemic countries and the malaria-free world. Some 90% of the burden falls on tropical Africa, where the disease is a major cause of mortality and morbidity in children under five years of age. Almost 60% of all malarial deaths are concentrated in the poorest 20% of the world's population, the highest association of any disease with poverty. Resistance to formerly effective treatment is increasing and has contributed to increasing mortality. Other parts of the world also have significant prevalence of malaria and need continued support from WHO.

Current malaria-control strategies are based on early and effective treatment (combination treatment, preferably artemisinin-based, for resistant falciparum malaria); prevention by vector control (in Africa, especially use of insecticide-treated nets); intermittent preventive treatment in pregnancy in areas where the epidemiological situation of malaria is stable; and prevention and control of epidemics.

The Roll Back Malaria project, initiated in 1998 with the goal of halving the number of malaria cases by 2010, led to the establishment of the Roll Back Malaria partnership and clarification of roles and responsibilities of WHO and the partnership in malaria control.

The Millennium Development Goals include combating malaria as one of the global targets for 2015, and 2001-2010 has been declared the Decade to Roll Back Malaria in Developing Countries, particularly in Africa. The year 2005 was the deadline for the commitment in the Abuja Declaration on Roll Back Malaria in Africa to achieve at least 60% coverage with the main malaria-control interventions; over the past few years progress towards these targets has been rapid.

The Global Fund to Fight AIDS, Tuberculosis and Malaria allocated more than US$ 942 million to malaria control on a five-year basis in its first three rounds of grant-making. This increased funding has provided a major opportunity for WHO and the Roll Back Malaria partnership to strengthen support for capacity development, implementation, monitoring and evaluation.

GOAL

To halve the burden of malaria by 2010 compared to 2000 and to reduce it further by 2015. (*Millennium Development Goal: By 2015 "halt and begin to reverse the incidence of malaria...".)*

WHO OBJECTIVES

To facilitate access of populations at risk to effective treatment of malaria; to promote the application of preventive measures against malaria for populations at risk; to build capacity for malaria control; to strengthen malaria-surveillance systems, and the monitoring and evaluation of control.

Indicators

- Death rates due to malaria and all causes among target groups
- Incidence of severe and uncomplicated cases of malaria among target groups
- Proportion of households having at least one insecticide-treated bednet
- Percentage of patients with uncomplicated malaria receiving correct treatment within 24 hours of onset of symptoms

STRATEGIC APPROACHES

Support for health ministries in essential public-health functions related to malaria control; promotion of synergies with related health programmes, especially those for immunization, child and maternal health, pharmaceuticals and environmental health; promotion of the participation of communities and civil society; engagement of the private sector in delivery of prevention and treatment; identification of best practices and financing mechanisms for extending interventions; preparation of tools and support measures for district-level management; expansion of WHO capacity at country level, together with HIV/AIDS and tuberculosis programmes.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Access of populations at risk to effective treatment of malaria promoted and facilitated through guidance on treatment policy and implementation.	• Proportion of malaria-endemic countries implementing policies on artemisinin-based combination therapy for falciparum malaria	40/100	50/100
	• Number of malaria-endemic countries in Africa implementing home-treatment programmes for uncomplicated malaria nationwide	18/44	35/44
2. Application of effective preventive measures against malaria for populations at risk promoted in disease-endemic countries.	• Proportion of malaria-endemic countries with insecticide-treated net strategy, through which at least 60% of target population is protected	30%	50%
	• Number of countries in Africa implementing the WHO recommended strategy on malaria in pregnancy	11/44	35/44
	• Number of malaria-prone countries that use weekly malaria-surveillance data in >80% of epidemic-prone districts	5	25/25 in Africa
3. Adequate support provided for capacity building in malaria control in countries.	• Number of countries where national institutions involved in malaria-control activities have been adequately strengthened	0	14
	• Number of countries using WHO human resource development guidelines to support malaria control	0	14
4. Malaria-surveillance systems and monitoring and evaluation of control programmes functioning at country, regional and global levels.	• Number of global reports on malaria	1	2
	• Proportion of malaria-endemic countries producing comprehensive annual reports and using effectively this information	To be determined	100%
5. Effective partnerships established and maintained for implementing the global Roll Back Malaria work plan to maximize countries' malaria-control performance.	• Number of malaria-endemic countries operating optimally to achieve 50% reduction in morbidity and mortality due to malaria	0	20
	• Percentage increase in resources channelled to malaria	25%	75%

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				137 934	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

Malaria is also supported by results expected to be achieved in other areas of work, as set out below.

Area of work	Expected result(s)

TUBERCULOSIS

ISSUES AND CHALLENGES

Although the impact of intensified control efforts is being felt in some regions, the tuberculosis epidemic continues to be a major public health problem globally, with currently 8.8 million new cases a year and about two million deaths worldwide. Some 80% of this morbidity and mortality falls on 22 "high-burden" countries. The internationally recommended tuberculosis-control strategy that includes directly observed treatment, short-course (DOTS)[1] is widely proven and highly cost effective. By 2002, 180 countries had introduced DOTS, but only 37% of all tuberculosis patients were cared for under this approach. Many small- to medium-sized countries are close to, or have achieved, the global control targets (namely, detection of 70% of infectious cases and 85% treatment success by 2005), but most populous countries with heavy case-loads of tuberculosis are falling short: either they adopted the strategy only recently or they have been slow to expand it, commonly because of lack of political commitment and of financial and human resources. In addition, weak primary health-care systems and failure to involve all care providers, both governmental and nongovernmental, in tuberculosis-control activities have seriously hindered the application of DOTS at all levels. Furthermore, the HIV/AIDS epidemic, economic and social disruption in many poor countries, and the emergence of multidrug resistance have undermined tuberculosis control. In countries with a high prevalence of HIV infection, the number of tuberculosis cases has quadrupled in the past 15 years. Drug resistance is a serious problem in several countries, with the prevalence of multidrug-resistant tuberculosis reaching 10% or more in countries of the former Soviet Union in eastern Europe and Central Asia and in parts of China.

The global movement to stop tuberculosis currently has more than 280 partners, including organizations in countries with a high burden of disease, bilateral and multilateral bodies, nongovernmental organizations, academic institutions and the private sector. The Washington Commitment to Stop TB (2001) supported the massive expansion of DOTS in order to reach the global targets by the end of 2005. Millennium Development Goal 6 includes rates of case detection, cure, prevalence and mortality as indicators of progress. The Global Plan to Stop TB, launched in 2001, sets out the actions to be undertaken to reach these goals, including expansion of DOTS coverage, extending new strategies to deal with HIV-associated tuberculosis and multidrug-resistant tuberculosis, and research and development for new diagnostic tools, drugs and vaccines. Finances and collaboration have increased in each of these areas, but not fast enough. By 2004, the Global TB Drug Facility had already provided drugs to 49 countries for use in expanding DOTS, reaching nearly two million patients. The Green Light Committee that provides access to second-line drugs for the effective treatment of multidrug-resistant tuberculosis had enabled DOTS-Plus projects for its management to be initiated in 14 countries by 2003.

New strategies are needed to tackle the epidemic of tuberculosis, starting with engagement of all governmental services providing care and expanding to involve communities, nongovernmental organizations and private practitioners in national control programmes. In addition, broader obstacles to tuberculosis control (such as insufficient social mobilization, weak primary care services, and the crisis in human resources) are to be faced.[2]

The Global Fund to Fight AIDS, Tuberculosis and Malaria has made grants on an unprecedented scale to countries to tackle tuberculosis; the World Bank and some bilateral donors have also increased support. WHO and these partners will continue to work closely with countries to ensure effective use of these new resources.

GOAL

All countries to reach the global control targets of 70% detection and 85% treatment success rates and to sustain this achievement in order to halve the prevalence and death rates associated with tuberculosis by 2015.

[1] See *Global tuberculosis control: surveillance, planning, financing: WHO Report 2004*. Geneva, World Health Organization, 2004.

[2] Document WHO/HTM/STB/2004.28.

WHO OBJECTIVES

To expand implementation of the DOTS strategy and strengthen tuberculosis control, by means including strategies and policies on tuberculosis/HIV coinfection and multidrug-resistant tuberculosis, and of increased involvement of communities, all health-care providers, nongovernmental organizations and corporate partners, through increased country support and by nurturing the Stop TB partnership; to strengthen surveillance, monitoring and evaluation; and to promote and facilitate research on new diagnostic tools, drugs and vaccines.

Indicators

- DOTS coverage
- Case-detection and treatment-success rates
- Tuberculosis prevalence, incidence and mortality rates
- Level of implementation of new approaches targeting, for example, tuberculosis/HIV coinfection, multidrug-resistant tuberculosis and communities
- Financial resources available for tuberculosis control

STRATEGIC APPROACHES

Existence of coordinated plans for DOTS expansion in the high-burden countries and in other countries with high tuberculosis prevalence rates; innovative means of involving all health-care providers and communities; provision of high-quality drugs through the Global TB Drug Facility; global advocacy and social mobilization to increase political commitment and engage communities; resource mobilization through the Global Stop TB partnership; rational use of second-line antituberculosis drugs; enhanced surveillance and monitoring, including of drug resistance.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. A global plan for DOTS expansion, geared to reaching Millennium Development Goal 6, implemented.	• Proportion of countries having long-term plans to achieve Millennium Development Goal 6	5/22	15/22
	• Global case detection rates	50%	70%
	• Global treatment-success rates	84%	85%
	• Global prevalence rate (per 100 000)	148	≤148
	• Global incidence rate (per 100 000)	222	≤222
	• Global mortality rate (per 100 000)	27	≤27
2. Implementation of long-term national plans for DOTS expansion and sustained tuberculosis control supported through functional national partnerships.	• Proportion of the 22 heavy-burden and other targeted countries with functional national partnerships against tuberculosis	26/87	43/87
3. Global TB Drug Facility and the Green Light Committee maintained and supporting expanded access to treatment and cure.	• Number of patients treated each year with support from the Global TB Drug Facility	4 million additional patients	4 million additional patients
	• Number of countries receiving adequate support from the Green Light Committee	40	60
4. 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.	• Number of targeted countries with internal and/or external financial resources sufficient to close the funding gap	30/87	40/87

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
5. Surveillance and evaluation systems at national, regional and global levels maintained and expanded to monitor progress towards targets, resource allocations for tuberculosis control, and impact of control efforts.	• Proportion of Member States submitting accurate annual surveillance, monitoring and financial reports for inclusion in the annual global report on tuberculosis control	185/192 for monitoring; 123 for financial reporting	192 for monitoring; 150 for financial reporting
	• Proportion of high-burden countries having assessed or measured impact of tuberculosis control on disease burden	5/22	10/22
6. Adequate guidance and support provided to countries to tackle multidrug-resistant tuberculosis and to improve tuberculosis-control strategies in countries with high HIV prevalence.	• Proportion of targeted countries implementing DOTS-Plus projects to manage multidrug-resistant tuberculosis	40%	50%
	• Proportion of countries with up-to-date data from drug-resistance surveillance	136/210 (65%)	147/210 (70%)
	• Number of countries with heavy disease burden due to tuberculosis and HIV infection implementing joint activities that involve collaboration between tuberculosis and HIV programmes	15	30
7. Better tuberculosis case-detection and cure rates promoted and supported through all public and private providers and community-based services, and integrated respiratory care implemented at primary level.	• Proportion of targeted countries expanding tuberculosis care through diversified care networks, using public-private entities and community interventions	20/87	40/87
	• Proportion of targeted Member States that have implemented guidelines to mobilize societies for tuberculosis cure and control	5/22	15/22
	• Number of countries with satisfactory tuberculosis-control services implementing integrated respiratory care at primary level	22	32

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				134 865	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

Tuberculosis is also supported by results expected to be achieved in other areas of work, as set out below.

Area of work	Expected result(s)

HIV/AIDS

ISSUES AND CHALLENGES

Tackling the HIV/AIDS epidemic remains among the greatest challenges in international public health. HIV/AIDS is now the leading cause of death in sub-Saharan Africa and the fourth worldwide. At the end of 2003, an estimated 40 million people were living with HIV/AIDS, 95% of them in developing countries, and more than 20 million people had died. In many developing countries, new infections occur mainly in young adults, especially young women. About one third of those currently living with HIV/AIDS are aged 15-24 years; most do not know they are infected. The impact of HIV/AIDS on development continues to be underestimated. The epidemic is destroying families and communities and sapping the economic vitality of the worst affected countries. Core government functions and national security are threatened by the toll of the disease among civil servants, teachers and health-care workers. In severely affected regions, it is undermining economic, social and political gains and crushing hopes for a better future.

Globally, about 8000 people die of AIDS-related conditions daily, notwithstanding the ability of antiretroviral therapy to delay disease progression and improve quality of life significantly. Although numerous projects have proven the feasibility of providing such therapy in developing countries, only 400 000 of the five to six million people in the advanced stages of the disease had access to that therapy in developing countries at the end of 2003. In Africa, where 70% of people with HIV/AIDS live, antiretroviral therapy was available to only 100 000 people – a mere 2% of those in need. Responding to this crisis in late 2003, WHO and UNAIDS declared the gap in treatment between high- and low-income countries as an international public health emergency, in response to which they initiated a plan to deliver treatment to at least half those in developing countries who needed it – 3 million people – by the end of 2005. The "3 by 5" target was an interim step toward the ultimate goal of universal access to antiretroviral therapy.

Sustained commitment to expanding interventions to prevent infection and disease is essential, but extending access to treatment will ensure that national responses to HIV/AIDS are comprehensive. It will also enable synergies between treatment and prevention to be exploited more effectively, for example, by stimulating demand for HIV testing, incorporating prevention into the care provided to people living with HIV/AIDS, and using opportunities created during outreach in prevention programmes to bring marginalized people into care. Above all, the introduction of antiretroviral therapy must contribute to overall improvements in health systems, for example, through the strengthening of existing infrastructures and referral mechanisms and greater use of entry points, including services for antenatal care, sexually transmitted infections, harm reduction and drug substitution, and community- or home-based care and tuberculosis-control programmes.

In developing countries where antiretroviral therapy is available, the reduced demand for inpatient services has contributed to overall cost savings in the health system. Simplified approaches to treatment and clinical monitoring also contribute to cost-savings and the long-term sustainability of antiretroviral therapeutic programmes. Such programmes also bring social benefits beyond the health sector through heightened awareness about HIV/AIDS, increased condom use, reduced stigmatization and discrimination, and regained productivity in the workforce.

More concerted efforts are required to ensure that the most vulnerable populations, including women, poor people in rural areas and injecting drug users, have access to HIV/AIDS services and to reduce stigmatization and discrimination, especially where they inhibit access to health services. Emerging priorities also include operational research and the development and application of new products such as clinical diagnostic tools, vaccines and microbicides.

Countries require continuing technical support in consolidating their HIV/AIDS programmes and surveillance mechanisms (including antiretroviral drug resistance), creating and managing strategic partnerships, strengthening procurement of drugs and diagnostics, mobilizing and absorbing new funds, assuring sustainable human resources within the health sector, and ensuring that the response to HIV/AIDS is further integrated within, and benefits, health systems as a whole.

GOAL

Effectively to control HIV/AIDS and mitigate its socioeconomic impact by accelerating prevention and by providing universal access to antiretroviral therapy.

WHO OBJECTIVES

Rapidly to expand access to treatment and care while accelerating prevention and strengthening health systems to make the health-sector response to HIV/AIDS more effective and comprehensive.

Indicators

- Number of developing and countries in transition providing comprehensive HIV prevention and care programmes
- Percentage of people with advanced HIV infection receiving antiretroviral therapy
- Number of health-care facilities that have the capacity and conditions to provide HIV testing and counselling, HIV/AIDS care and antiretroviral treatment

STRATEGIC APPROACHES

Continued advocacy for universal access to antiretroviral therapy as a human right; brokering of new, and support for existing, partnerships as part of the comprehensive response to the epidemic; capacity building for strengthening health systems in order to facilitate countries' expansion of HIV/AIDS responses; formulation and updating of high-quality guidelines, tools and training packages; continuous documentation of lessons learnt and best practices and their dissemination for application.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Support provided to countries to build national capabilities and technical expertise for improving health-system responses to HIV/AIDS, sexually transmitted infections and related conditions, including planning, resource mobilization, training and service delivery.	• Number of countries receiving support to build health-sector competencies in HIV/AIDS, sexually transmitted infections and related conditions using WHO normative tools and resources	50	100
2. Involvement of affected communities in global, national and local health-sector responses to the HIV/AIDS epidemic increased.	• Number of countries that involve affected communities in planning, implementation and delivery of HIV/AIDS health services	50	100
3. Support provided to countries to ensure uninterrupted supply of HIV-related supplies and equipment.	• Number of countries using AIDS medicines and diagnostics service to support procurement and distribution of HIV-related supplies and equipment	50	100
4. Appropriate set of evidence-based technical tools developed and provided to countries to enhance essential health-sector interventions and services for treatment, care, prevention and support of people with HIV and related conditions.	• Number of countries using or adapting WHO tools and resources on prevention and management of HIV/AIDS and related conditions including tuberculosis and sexually transmitted infections	50	100
5. Application of operational research and knowledge management processes by local and national-level implementers.	• Number of countries with operational research and knowledge management programmes receiving support from WHO	50	100

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				261 013	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

HIV/AIDS is also supported by results expected to be achieved in other areas of work, as set out below.

Area of work	Expected result(s)

SURVEILLANCE, PREVENTION AND MANAGEMENT OF CHRONIC, NONCOMMUNICABLE DISEASES

ISSUES AND CHALLENGES

The growing burden of chronic, noncommunicable diseases is a consequence of global trends, including urbanization, population ageing and behavioural change, and the failure of disease prevention, diagnosis and management. Common, preventable biological risk factors (such as high blood pressure, high concentrations of total cholesterol and overweight) and related behavioural risks (unhealthy diet, physical inactivity and tobacco use) lead to four major conditions: cardiovascular disease, cancers, chronic obstructive pulmonary disease and type 2 diabetes. Preventable visual and hearing impairment is estimated to affect more than 180 million and 250 million people, respectively. Mortality, morbidity and disability attributable to chronic, noncommunicable diseases caused 60% of all deaths – most (79%) in the developing countries –and 47% of the global burden of disease in 2001. Without action being taken, these figures are expected to rise by 2020 to 73% of all deaths and 60% of the global burden of disease. Effective interventions are available for the prevention and management of chronic, noncommunicable diseases, but are not used widely or equitably. Much of the cost of diagnosis and management will fall on developing countries, many still suffering from the burden of under-controlled communicable diseases, and the expected overall costs for countries suffering this double burden of disease are high. In total, chronic illness accounts for almost 70% of all medical spending, much of this in direct payment by patients, so contributing to family poverty. Meeting these challenges requires global commitment and comprehensive national responses combining surveillance, prevention and management.

For surveillance to be effective, standardized, comparable data need to be collected regularly and used for implementing appropriate health policies. WHO's STEPwise approach to surveillance supports low- and middle-income countries in developing sustainable surveillance systems for chronic, noncommunicable diseases, and encourages countries to collect information on major risk factors with standardized methods. It is being applied in four WHO regions. Additional work is needed to include other countries and to compile this information in the global and regional databases for analysis and dissemination. A new challenge is to translate all the data being collected into information that leads to beneficial changes in national health policies.

National programmes are being established within the framework of the global strategy for prevention and control of noncommunicable diseases, as urged by the Health Assembly in 2000.[1] These programmes are linked by regional and global networks which facilitate the implementation of initiatives in countries and share available regional experience. WHO's recently endorsed Global Strategy on Diet, Physical Activity and Health[2] now needs to be implemented at national, regional and global levels, with the support of established and new regional networks. Successful prevention of chronic, noncommunicable diseases is based on a life-course approach and needs appropriate interventions, including health promotion, starting in childhood and adolescence and continuing throughout the lifespan, resulting in healthy ageing.

For disease-specific and generic interventions to be implemented, primary and secondary prevention need to be integrated into health services. Countries need policies, practical tools and instruments in order to adapt or strengthen the ability of health systems to deal with the increasing burden of chronic, noncommunicable conditions. A challenge is to foster relevant partnerships within countries in order to facilitate the changes in health-service delivery that will be necessary to implement effective disease-specific interventions.

GOAL

To reduce the burden of premature mortality and morbidity related to chronic, noncommunicable diseases.

[1] Resolution WHA53.17.

[2] Resolution WHA57.17.

WHO OBJECTIVES

To build surveillance systems; to reduce exposure to the major risk factors; and to help health systems respond appropriately to the rising burden of chronic, noncommunicable diseases.

Indicators

- Regional burden of chronic, noncommunicable diseases
- Disability-adjusted life years related to avoidable blindness and deafness

STRATEGIC APPROACHES

Comprehensive integrated and collaborative response by countries and WHO through surveillance, prevention and management of the main chronic, noncommunicable diseases and their common risk factors; availability of comprehensive, country-level data on chronic, noncommunicable diseases and their risk factors to all Member States through WHO regional offices; support to all Member States for incorporating evidence-based information on integrated prevention and control of chronic, noncommunicable diseases into the health policy; networks in all WHO regions to support the implementation of programmes based on integrated prevention and control policies for chronic, noncommunicable diseases; promotion of community participation in prevention and management.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Effective guidance and support, including standardized methods and materials, provided for implementation of WHO's surveillance framework for chronic, noncommunicable diseases and their risk factors in low- and middle-income countries.	• Number of countries that collect and analyse data on chronic, noncommunicable diseases and their risk factors and make results available to policy-makers	35 countries	80 countries
	• Proportion of low- and middle-income countries out of those with initial surveillance data collections that regularly collect surveillance data on chronic, noncommunicable diseases	0%	10% of countries
2. International standards for collection, analysis and dissemination of data on chronic, noncommunicable diseases and their major modifiable risk factors established, in order to improve the quality, availability and comparability of such data.	• Availability of comparable data on risk factors for chronic, noncommunicable diseases in WHO's global database and in the report on surveillance of risk factors	No existing comparable data available for Member States in *Surveillance of Risk Factors Report 1*	Comparable risk factor data for all Member States, with projections of future prevalence in *Surveillance of Risk Factors Report 2*
	• Existence of standards for data on risk factors for chronic, noncommunicable diseases	No standard risk-factor definitions available	Standardized definitions for all modifiable risk factors for chronic, noncommunicable diseases
	• Comprehensive availability of specific information on chronic, noncommunicable diseases and their risk factors in the global databases	Specific information on stroke and diabetes included in the global database	Specific information on stroke, diabetes, cardiovascular diseases, oral health, respiratory diseases, genetic diseases, blindness and deafness included in the global database
	• Number of WHO regions that have dedicated, up-to-date databases on noncommunicable diseases	1 region with a dedicated database	All 6 regions with dedicated databases

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
3. Evidence-based public health information produced and adequate support provided to countries for use in informing policies and strategies for prevention and management of chronic, noncommunicable diseases at national level, including integration of primary and secondary prevention into health systems.	• Number of targeted countries using evaluated and revised WHO guidelines for the prevention, management and control of chronic, noncommunicable diseases	Number of targeted countries using current WHO guidelines for prevention, management and control of chronic, noncommunicable diseases	Number of targeted countries using revised WHO guidelines for prevention, management and control of chronic, noncommunicable diseases
	• Provision of information on the status of chronic, noncommunicable diseases, their prevention, management and control	Global report on chronic, noncommunicable diseases	Follow-up report on chronic, noncommunicable diseases
4. Multisectoral strategies that can be translated into plans of action on diet and physical activity validated and adequate support provided to priority countries.	• Proportion of targeted regions and countries with multisectoral strategies and plans on diet and physical activity	Proportion of Member States with multisectoral strategies and plans on diet and physical activity	Proportion of Member States with multisectoral strategies and plans on diet and physical activity
5. Strengthened ability of targeted countries to progress towards the elimination of avoidable visual and hearing impairment as a public health problem.	• Number of countries setting up national plans to eliminate avoidable visual and hearing impairment as a public health problem	Monitoring report on avoidable visual and hearing impairment	120 countries setting up national plans to eliminate avoidable visual and hearing impairment

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				56 300	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

Surveillance, prevention and management of chronic, noncommunicable diseases is also supported by results expected to be achieved in other areas of work, as set out below.

Area of work	Expected result(s)

HEALTH PROMOTION

ISSUES AND CHALLENGES

Most countries are experiencing unprecedented societal transformation as a result of population growth and urbanization together with environmental and other changes. This process is often accelerated by globalization in trade and communication, and complex emergencies. New approaches are required in the light of these changes in order to address the broader determinants of health.

Within the context of primary health care, health promotion is critical to improving outcomes in the prevention and control of both chronic and communicable diseases, and in meeting the health-related Millennium Development Goals, particularly among poor and marginalized groups. In order to accomplish these aims, WHO applies health promotion techniques to health and related social systems, and to a variety of risk factors, diseases and health issues, including oral health. Carrying out health promotion in settings where people live, work, learn and play is a creative and effective way of improving health and quality of life. Health promotion has a crucial role to play in fostering healthy public policies and health-supportive environments, enhancing positive social conditions and personal skills, and promoting healthy lifestyles.

The capacity and infrastructure for the planning and implementation of multisectoral health promotion policies and programmes need to be strengthened in most regions. Most countries lack the policies and the human or financial resources necessary for sustainable, effective health promotion to counter risks and their underlying determinants. For this reason, there is an urgent need to orient health systems more towards health promotion and to build their capacity to promote health (e.g., by developing new and innovative ways for securing sustainable funding and accurate and updated health promotion profiles, strengthening education and training, and expanding the evidence base for health promotion).

Advocacy and social mobilization for policy in support of health promotion are also vital. Effective policies need to be multisectoral; they must draw upon a broad range of partners, including the wider community, for their development and implementation. Governments must play a stronger role in developing healthy public policies; health ministries need to take the lead by advocating for the development and adoption of these policies.

In accordance with resolution WHA51.12 requesting that health promotion should be given top priority within WHO, and in line with the global conferences held in Ottawa (1986), Adelaide, Australia (1988), Sundsvall, Sweden (1991), Jakarta (1997) and Mexico City (2000), health promotion needs to be strengthened in all areas of work in order to support Member States more effectively.

GOAL

To improve equity in health, reduce health risks, promote healthy lifestyles and settings, and respond to the underlying determinants of health.

WHO OBJECTIVES

To develop and implement multisectoral public policies for health, integrated gender- and age-sensitive approaches that facilitate community empowerment together with action for health promotion, self-care and health protection throughout the life course in cooperation with the relevant national and international partners.

Indicators

- Degree of integration of health promotion into national health strategies and services and appropriate settings
- Sustainability of financing of health promotion interventions in countries

STRATEGIC APPROACHES

Advocating for policy support and investment in the development of health systems and services that support health promotion and risk prevention; fostering health-supportive environments and integrated approaches to public health services; strengthening the sustainable financing and evidence base required for health promotion; increasing the knowledge base for tackling the broad determinants of health.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Increased guidance for integrating health promotion, including ageing and oral health, into health systems.	• Number of countries that have integrated strategies for health promotion throughout the life course into national health plans	19	25
2. Capacity for governance, stewardship, planning and implementation of multisectoral health promotion policies and programmes strengthened at country and regional levels, based on gender-sensitive approaches to promoting health and well-being throughout the life course.	• Number of countries that have accurate and updated country profiles on health promotion and risk factors	48	54
	• Number of university public health/health promotion degree programmes, at national or provincial level in low- and middle-income countries, with strengthened capacity	40	44
	• Number of countries that have health impact assessment in place for new public policies	15	25
3. Evidence validated and disseminated of the effectiveness of health promotion strategies and interventions to tackle communicable and noncommunicable diseases.	• Number of intervention studies demonstrating the effectiveness of health promotion in low- and middle-income countries published in professional journals	5	10
4. New and innovative approaches applied to sustainable financing of health promotion interventions and capacity building at national, local and community levels.	• Number of health promotion foundations, or other means for financing health promotion, established in countries	6	9
5. Increased capacity of ministries of health and education to plan, implement and evaluate school health programmes for the reduction of risks associated with leading causes of death, disease and disability.	• Number of countries that have implemented the Global School-based Student Health Survey, or the survey on Health Behaviour in School-aged Children	46	64
6. Increased guidance to curtail social, economic and political policies and practices that undermine the effects of health promotion programmes and that glorify and encourage risk-taking behaviour, particularly among young people.	• Availability of WHO guidelines for fostering and encouraging healthy behaviours, and for curtailing policies and practices that undermine young people's health	0	10

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				48 400[b]	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

[b] Including US$12 000 for the Kobe Centre.

Health promotion is also supported by results expected to be achieved in other areas of work, as set out below.

Area of work	Expected result(s)

MENTAL HEALTH AND SUBSTANCE ABUSE

ISSUES AND CHALLENGES

The proportion of the global burden of disease attributable to mental and neurological disorders and those related to substance use is expected to rise from 12.3% in 2000 to 16.4% by 2020. Alcohol consumption alone is responsible for 4%. More than 150 million people suffer from depression at any point in time and nearly one million commit suicide every year. There are some 10 million injecting drug users worldwide and 4% to 12% of all HIV cases are transmitted through injecting drug use. The impact of mental and neurological disorders and those related to substance use will become particularly severe in developing countries, primarily because of the projected increase in the number of individuals entering the age of risk for the onset of such disorders. Most affected are vulnerable groups, such as people living in absolute and relative poverty, those coping with chronic diseases and those exposed to emergencies.

As a result of resolutions adopted on strengthening of mental health,[1] governments are now more aware of the negative impact of mental and neurological disorders and those related to substance use on families, communities, and individuals. Nevertheless, governments need to give higher priority to mental health. Worldwide, a huge gap still exists between needs and the implementation of the cost-effective treatments that are available for most of those disorders. Reducing this gap and improving treatment rates will reduce the burden of disease and disability and health-care costs while increasing economic and social productivity. Cases of depression could be halved and a quarter of suicides could be prevented, for instance, if appropriate care were given. To bridge the gap, it is essential that innovative mental-health policies and legislation should be designed and integrated into health systems. Promoting mental health, preventing mental disorders, incorporating cost-effective interventions into the mainstream of primary health care, and engaging local communities are key components of these policies.

GOAL

To reduce the burden associated with mental and neurological disorders and those related to substance abuse, and to promote mental health worldwide.

WHO OBJECTIVES

To ensure that mental health and the consequences of substance abuse are taken fully into account in considerations of health and development, to formulate and implement cost-effective responses to the burden of mental and neurological disorders and those related to substance use, and to promote mental health.

Indicators

- Proportion of countries that have strengthened policies and services for reducing the burden of mental and neurological disorders and those related to substance use, and for promoting mental health
- Proportion of countries that have taken specific measures to protect the rights of people with mental and neurological disorders and those related to substance use
- Proportion of countries that have implemented evidence-based cost-effective intervention strategies for mental-health promotion, prevention and management of mental and neurological disorders and those related to substance use

STRATEGIC APPROACHES

Dissemination of information on the magnitude, burden, determinants and cost-effective services for the prevention and treatment of mental and neurological disorders and those related to substance use; provision of support to countries for formulating and implementing coherent and comprehensive policies, legislation and services for prevention and treatment of mental and neurological disorders and those related to substance use, for fighting against discrimination and abuse of the rights of people with such disorders, and for the development of human resources for mental health, including research capability, with emphasis on developing countries.

[1] Resolutions EB109.R8 and WHA55.10.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Support provided to priority countries and countries facing complex emergencies for institutional capacity strengthening in order to develop and implement policies and plans on mental health and substance abuse.	• Number of countries receiving WHO support that have developed policies and plans for mental health (including alcohol and illicit drugs) with achievable targets • Number of targeted countries that have received WHO support to deal with the mental-health consequences of emergencies		
2. Support provided for capacity building in countries in order to develop mental-health legislation, to protect rights of people with mental and neurological disorders and those related to substance use, and to reduce stigmatization and discrimination.	• Number of countries receiving WHO support that have effectively reviewed or updated mental-health legislation and/or initiated projects to monitor observation of human rights		
3. Services, research capacity and information systems on mental health and substance abuse within Member States strengthened and supported.	• Number of countries in which performance of mental-health systems and services has been monitored within WHO's framework of reference • Number of global databases revised and updated on the basis of inputs from countries with gender-disaggregated data		
4. Support provided to improve countries' capability to develop evidence-based strategies, programmes and interventions for prevention and management of mental and neurological disorders, including suicidal behaviours.	• Percentage of people with epilepsy in selected countries that are untreated • Number of countries receiving WHO support that have developed effective gender-specific interventions for prevention of suicidal behaviours and/or management of mental and neurological disorders		
5. Guidance and support provided to countries for development of evidence-based strategies, programmes and interventions for prevention and management of disorders related to substance use and reducing the adverse health and social consequences of use of alcohol and other psychoactive substances.	• Number of countries receiving WHO support that have trained staff and developed appropriate programmes for prevention and management of disorders related to substance use and integrated them within primary health care • Number of countries receiving WHO support that have improved the coverage and quality of drug-dependence treatment directed towards HIV prevention and care for injecting drug users		

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				29 855	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

Mental health and substance abuse is also supported by results expected to be achieved in other areas of work, as set out below.

Area of work	Expected result(s)

TOBACCO

ISSUES AND CHALLENGES

Currently, 1300 million people use tobacco, and that number is expected to rise. Tobacco continues to be the second major cause of death in the world. Half today's tobacco users will eventually be killed by tobacco – most of them in developing countries. Tobacco also contributes to the continuing poverty of low-income households and countries because money is spent on tobacco rather than on food, education and health care.

With globalization, the tobacco industry has continued to expand its search for new markets in developing countries. In response to the consequent spread of tobacco use, the Health Assembly unanimously adopted WHO's first global treaty, the WHO Framework Convention on Tobacco Control, in May 2003.[1] The treaty will enter into force once it has been ratified by 40 Member States. As the interim secretariat for the Convention, WHO provides technical support to Member States and will convene the first session of the Conference of the Parties when the treaty enters into force.

Building human and institutional capacity remains a major challenge for tobacco control worldwide. Few countries have the infrastructure that will enable them to implement the comprehensive measures needed to reduce tobacco use significantly. Many countries are still wary of the potential impact of tobacco-control measures on their national economies. Nevertheless, there exist many feasible and cost-effective interventions that dramatically cut tobacco consumption rates without harming economies. WHO's major task in 2006-2007 will be to recommend policies, promote interventions and develop and implement varied approaches to build capacity in those countries that are Parties to the Framework Convention, those that have signed but not ratified the treaty, and those that have not yet signed it.

WHO will also work to counter the activities of the tobacco industry, which continues to use its considerable influence to undermine tobacco-control policies and programmes in many countries. Tobacco-product regulation will also need to be given attention, as tobacco products have so far enjoyed an unprecedented degree of freedom from the regulations that apply to other consumer products.

Coordination will be needed to ensure that tobacco control is integrated into other relevant technical areas of work such as Tuberculosis, Child and adolescent health, Health promotion and Management of noncommunicable diseases. Lastly, WHO will continue to keep issues related to tobacco use in the public gaze by working with local, national and international nongovernmental and health professional organizations and by sponsoring awareness-raising and World No Tobacco Day campaigns. The work of the United Nations Ad Hoc Inter-Agency Task Force on Tobacco Control will also continue to be important in addressing the multisectoral aspects of tobacco control.

GOAL

To protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke.

WHO OBJECTIVES

To reduce continuously and substantially both tobacco use and exposure to tobacco smoke, by putting in place effective tobacco-control measures and providing support to Member States in implementing the WHO Framework Convention on Tobacco Control.

Indicators

- Number of countries that are Parties to the Framework Convention
- Number of countries with effective tobacco-control policies and plans that take account of the provisions of the Convention

[1] Resolution WHA56.1.

STRATEGIC APPROACHES

Maximizing of the number of Member States becoming Parties to and implementing the Convention; provision of secretariat service to the Convention; maintenance of countries' awareness of tobacco-industry activities nationally and internationally; highlighting of the links between tobacco use and poverty; provision of support for research on economic interventions and promotion of behavioural change for tobacco control; collaboration with health professional organizations; reinforcement of countries' ability to implement strong, gender-sensitive tobacco-control measures through national capacity building in the areas of surveillance, research, legislation, economics, health education, tobacco-use cessation, advocacy, tobacco-product regulation and monitoring and assessment systems, recognizing the special needs of young people and indigenous communities and their members.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Number of Member States with tobacco-control policies and plans of action reflecting the provisions of the Framework Convention increased; best practices in tobacco control collected and disseminated as a supporting measure.	• Number of countries that have adopted legislation or its equivalent in relation to the following settings and articles: health-care and educational facilities (ban on smoking), national media (ban on direct advertising of tobacco products), tobacco products that meet the criteria set forth in the Framework Convention (health warnings)	40	80
	• Number of tobacco-control success stories, and lessons learnt, published and disseminated by WHO	35	50
2. Multisectoral collaboration on tobacco control increased.	• Number of new projects initiated under the umbrella of the United Nations Ad Hoc Inter-Agency Task Force on Tobacco Control	9	12
	• Worldwide membership of GLOBALink	4 500	5 500
3. Capacity for surveillance and research in support of tobacco control increased in the areas of health, economics, legislation, environment and behaviour.	• Number of countries that have completed the Global Youth Tobacco Survey at least twice	40	80
	• Number of countries covered by a global information system on tobacco control	80	192
	• Number of economic and intervention-based research studies supported by WHO	12	20
4. Public awareness of the dangers of tobacco raised through strong media coverage and comprehensive information on web site.	• Number of countries that celebrate World No Tobacco Day	60	80
	• Average number of web site hits per month	40 000	45 000
5. Regulation and public awareness of tobacco-industry activities increased.	• Number of published results of country-specific research on tobacco industry activities	20	25
6. Knowledge of testing methods for effective tobacco-product regulation improved.	• Number of recommendations published by the WHO Study Group on Tobacco Product Regulation	8	10
7. Number of Member States that ratify, accept, approve, formally confirm or accede to the Framework Convention increased.	• Number of Member States that are Parties to the Framework Convention	40	70

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				29 282	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

Tobacco is also supported by results expected to be achieved in other areas of work, as set out below.

Area of work	Expected result(s)

NUTRITION

ISSUES AND CHALLENGES

Hunger and malnutrition are intricately bound up with ill-health, poverty and underdevelopment. Food insecurity threatens 800 million people. Freedom from hunger and malnutrition is a basic human right, and their alleviation is a fundamental prerequisite for human and national development.

The past decade has seen some measurable success in reducing the global burden of malnutrition. Nevertheless, nutritional deficiencies still remain responsible for massive mortality and morbidity, especially in pregnant women and young children, worldwide. Some 21 million babies are born every year with low birth weight. Fully 60% of the 10.9 million deaths among children aged under-five each year in developing countries are associated with underweight due to malnutrition, and 161 million preschool children suffer chronic malnutrition. One third of the world's population is affected by vitamin and mineral deficiencies and therefore subject to infection, birth defects and impaired physical and psycho-intellectual development. In countries facing emergencies, malnutrition affects nearly 40 million people and is one of the major causes of death and disability. The 40 million people living with HIV/AIDS are exposed to an increased risk of food insecurity and malnutrition, especially in poor settings, which may combine to aggravate their condition.

At the same time, both industrialized and rapidly industrializing countries are seeing the large-scale emergence of overweight and obesity as a result of unhealthy diets and sedentary lifestyles. Some 1000 million adults and 20 million children are estimated to be overweight. More than half the world's population is affected by some form of diet- and nutrition-related chronic disease, which is increasing death rates and lost years of healthy life from cardiovascular diseases, type 2 diabetes and some cancers.

A number of countries face the dual burden of both over- and under-nutrition in their populations, which places increased strain on health systems, reduces economic performance and impacts on social and economic development.

WHO's fundamental role in tackling these challenges, and therefore contributing to the achievement of the health-related Millennium Development Goals, is to strengthen the ability of Member States to identify and reduce all forms of malnutrition, and to promote healthy nutrition and diet. In that respect, WHO has a unique strength through its work on setting norms and standards at global level and developing strategies to counter malnutrition, and through its close relations with national health authorities by means of its regional and country offices.

GOAL

To eliminate malnutrition in all its forms.

WHO OBJECTIVES

To reduce malnutrition through the promotion of healthy nutrition and diet, and strengthening of national nutrition policies and programmes.

Indicators

- Number of countries with effective policies and programmes to control malnutrition
- Number of countries that have made progress towards the Millennium Development Goals related to nutrition

STRATEGIC APPROACHES

Evidence-based actions to tackle all forms of malnutrition throughout the life-course, and promotion of national nutrition policies and programmes by setting up norms and standards; providing technical support and guidance to countries; strengthening national nutrition-surveillance systems; promoting public advocacy and mobilization of public health authorities; and collaborating with organizations of the United Nations system, public- and private-sector bodies, and civil society.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Ability of countries to develop and implement national nutrition policies strengthened, including for tackling the nutrition transition, emergency situations and populations with HIV/AIDS.	• Number of countries with an effective national nutrition policy in place	146 countries	15 additional countries
2. Adequate guidance and support provided for implementation of WHO's global strategy on infant and young child feeding.	• Number of countries with an effective strategy on infant and young child feeding in place	No data available	50 countries
	• Number of WHO regions with locally adapted guidelines on implementation of WHO's global strategy on infant and young child feeding	No data available	All six WHO regions
3. Global, regional and national nutrition-surveillance systems strengthened through the maintenance and updating of WHO databases on nutrition.	• Number of countries with nationally representative data on major forms of malnutrition in WHO databases	92-187 countries (depending on databases)	120-190 countries (depending on databases)
4. Adequate guidance and support provided for implementation of the new WHO growth standards for assessment of child malnutrition, growth and development.	• Number of targeted countries receiving WHO technical support in implementing WHO's new growth standards	No data available	50 countries
5. Provision of support to countries for effective implementation of WHO's guidance on management of severe childhood malnutrition and evaluation of its impact on child mortality.	• Number of countries receiving WHO technical support in implementing and evaluating WHO's guidelines on management of severe childhood malnutrition	30 countries	50 countries
6. Provision of support to countries for effective implementation of a strategy for fetal development and control of maternal and fetal malnutrition, including low birth weight.	• Number of countries that have implemented an effective strategy for prevention and control of maternal and fetal malnutrition	No data available	40 countries
7. Provision of support to countries for effective implementation of policy on control of micronutrient malnutrition in the most susceptible groups, focusing on iodine, vitamin A, iron, zinc and folic acid deficiencies.	• Number of countries with national programmes on micronutrient-deficiency control which will be assessed	4 countries	10 countries

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
8. Provision of support for effective implementation of WHO's guidance on control of obesity and on promotion of healthy diet and lifestyles.	• Availability of WHO guidelines on the control of obesity and the promotion of healthy diet and lifestyles	Guidelines produced in 2 regions	Guidelines available in 4 regions
9. Ability to manage nutrition disorders in populations in emergency situations and in populations with HIV/AIDS.	• Number of WHO regions with locally adapted WHO guidelines on the management of nutrition disorders in emergency situations and in populations with HIV/AIDS	1 strategy document and 8 guidelines	Guidelines adapted for each of the 6 regions

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				24 183	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

Nutrition is also supported by results expected to be achieved in other areas of work, as set out below.

Area of work	Expected result(s)

HEALTH AND ENVIRONMENT

ISSUES AND CHALLENGES

Environmental conditions, whether affected by global change or within a local setting, are a major direct and indirect determinant of human health. In developing societies, exposure to modern forms of urban, industrial and agrochemical pollution aggravates the burden of disease stemming from traditional health risks within the household and community. Breaking the vicious cycle that links poverty, environmental degradation and ill-health, and redressing the continuing inequities related to gender and economic development, remain a major challenge.

Use of biomass fuel and coal for cooking and heating is estimated to be responsible for more than 1.6 million lives lost every year; almost 60% of the dead are children under five years of age. Safe and sufficient drinking-water is still not accessible to 1100 million people, and 2400 million lack adequate sanitation. Reduced availability and degraded quality of water, related to population growth and exploitation of natural resources, lead to 3.4 million deaths a year, mostly among the poor and children. Chaotic urban growth has its price in terms of environmental health: lack of clean forms of energy, safe water, sanitation, and disposal of municipal and hazardous waste remains a problem in many regions.

Occupational diseases and injuries, which are grossly underreported, are responsible for more than one million deaths annually. Increased use of chemicals, their mismanagement and inappropriate disposal – particularly of pesticides in developing countries – lead to a significant burden of injury, ill-health and mortality.

Climate change and increased levels of ultraviolet radiation contribute to increasing the burden of disease. Impacts include a growth in health hazards, from greater intensity and number of extreme weather events such as heat waves, floods or droughts, to changing patterns in vector-borne diseases. Accidental releases or the deliberate use of biological and chemical agents or radioactive material that affect health require effective prevention, surveillance and response systems to contain or mitigate harmful outcomes. Essential health services and basic sanitary installations are often disrupted or devastated as a consequence of conflict or environmental disasters.

Political, legislative and institutional barriers to improving environmental conditions are numerous. The public-health impact of different policy options needs to be properly assessed and cost to the health system of diseases attributable to environmental exposures, estimated. Human resources adequately specialized in risk assessment and management, and public participation on those processes, are still lacking in many countries. National and local health authorities are thus often unable to collaborate with other socioeconomic sectors where health-protective measures need to be taken.

Agenda 21, adopted at the United Nations Conference on Environment and Development (Rio de Janeiro, Brazil, 1992), the Plan of Implementation of the World Summit on Sustainable Development (Johannesburg, South Africa, 2002), together with the Millennium Development Goals and such regional initiatives as the series of ministerial conferences on environment and health, provide the necessary international policy framework for action.

GOAL

To achieve safe sustainable and health-enhancing human environments, protected from biological, chemical and physical hazards, and secure from the effects of global and local environmental threats.

WHO OBJECTIVES

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

Indicator

- Level of commitment to protection of environmental health reflected in policy declarations and development programmes, at national, regional and international levels

STRATEGIC APPROACHES Contribution to reducing the burden of excess mortality and disability by reducing risk factors to human health that arise from environmental causes; promotion, through the health sector, of interventions for health protection in the environment and other socioeconomic sectors; coordination of action across programmes within WHO, on the basis of proven strategies such as the "healthy settings" approach.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Evidence-based normative and good practice guidance developed or updated and promoted that effectively provide support for countries in assessing health impacts and in decision-making across sectors, in key environmental-health areas including water, sanitation and hygiene, air quality, workplace hazards, chemical safety, radiation protection, and environmental change.	• Number of countries using WHO guidance for risk assessment and management	18	35
2. Countries adequately supported in building capacity to manage environmental health information, and to implement intersectoral policies and interventions for protecting health from immediate and longer-term environmental threats.	• Number of countries implementing environmental and health action plans with WHO's support	40	51
3. Environmental health concerns of vulnerable and high-risk population groups (particularly children, workers and the urban poor) addressed by global, regional and country-level initiatives that are implemented through effective partnerships, alliances and networks of centres of excellence.	• Number of projects implemented in partnerships at national, regional and global levels	24	27

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				90 800	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

Health and environment is also supported by results expected to be achieved in other areas of work, as set out below.

Area of work	Expected result(s)

FOOD SAFETY

ISSUES AND CHALLENGES

Globally, unsafe food results in disease for at least one person in three every year, and in some regions the situation is considerably worse. Many cases result in long-term complications or death, and unsafe food, in addition to unsafe water, cause diarrhoeal diseases that kill an estimated 1.8 million people annually. These diseases also interact in a vicious circle with malnutrition, resulting in an even greater indirect burden of disease. In addition, foodborne chemical hazards still cause significant public-health problems, although their extent is difficult to estimate. There are clear indications that the incidence of foodborne disease is increasing. In addition, both the number and international importance of severe episodes of food contamination seem to be rising. These trends have substantial political implications, considerable changes to old food-safety systems are being contemplated throughout the world. Although food-safety issues have in the past been accorded low priority in many health systems, it is now recognized that serious health-sector involvement in food safety is necessary in order to guide interventions aimed at lowering disease incidence. Future food-safety systems and interventions need to be based on risk, that is start and end in relation to health.

Food-safety issues influence growth in international food trade because of their public health significance: food trade increases the potential to disseminate foodborne hazards. The need for international precaution in trade is evident. Such precaution requires a regulatory system based on objective and transparent criteria. In recent years several countries have lost significant export earnings from restrictions on food trade, yet no international system exists to tackle such challenges, or even to exchange information on food-related emergencies. Similarly, issues related to new technologies, such as food biotechnology, need to be recognized and resolved at international level.

In many countries the legislation and policies to guide food safety are either non-existent or outdated. Responsibility may be divided between a number of ministries with poor coordination; activities may not be based on risk nor with WHO/FAO guidance; there may be no surveillance of foodborne disease and education and training for food handlers and consumers in food safety is poorly developed.

GOAL

To reduce the health effect of food contamination and to reform and strengthen existing food-safety systems to reduce the burden of foodborne disease.

WHO OBJECTIVES

To enable the health sector, in cooperation with other sectors and partners, effectively and promptly to assess, communicate and manage foodborne risks.

Indicator

- The increase in the number of countries providing data on foodborne diseases and food hazards, which demonstrates that they are developing a risk-based approach to food safety assessment, management and communication

STRATEGIC APPROACHES

Building of capacity nationally and internationally to obtain, use and share reliable data on foodborne diseases and food contamination; promotion of risk assessments and risk-based decisions; formulation of international food safety standards and guidelines; furtherance of effective participation of more countries in the work of the Codex Alimentarius Commission; promotion of concept of food safety as an intersectoral responsibility at both technical and policy levels; building of risk-communication capability in Member States; advocacy of a coordinated approach at international, regional and country levels in order to handle more effectively the shared responsibility for food safety from production to consumption.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Foodborne disease surveillance and food-hazard monitoring and response programmes strengthened and international networks established.	• Percentage of WHO Member States participating in networks	60%	100%
	• Percentage of Member States providing surveillance data to WHO on one or more foodborne diseases, or reporting data from monitoring of microbiological or chemical hazards	Percentage of Member States reporting data at the end of 2005	At least 50% in each region
2. Timely provision of scientific advice and guidance to developing countries in order to increase their capability to assess risk, and to enable them to participate actively in international risk assessment.	• Number of international risk assessments (microbiological and chemical) finalized by WHO and FAO	Estimated 69 international risk assessments conducted in 2004-2005	Double the number of risk assessments
	• Number of participants from developing countries in WHO/FAO expert advisory bodies	Number recorded in 2004-2005	25% increase
3. Adequate technical guidance provided to countries to assess and manage the risks and benefits associated with products of new food technologies.	• Number of risk assessments, or tools, for risk assessment or management, validated and disseminated by WHO	4 risk assessments of genetically modified foodstuff in developing countries	2 consultations held on risk assessment; one set of guidelines issued
4. Effective support provided to countries for the organization and implementation of multisectoral food-safety systems, focusing on health and participation in international standard-setting.	• Percentage of countries in each region participating actively in international standard-setting (Codex Alimentarius Commission)	Percentage of countries in each region participating in standard-setting meetings in 2004-2005	At least 60% of countries in all regions participating in standard-setting meetings
	• Number of countries that, with WHO support, have established or amended policies, plans of action, legislation or enforcement strategies for food safety	3 countries per region in 2004-2005	Additional 5 countries per region
5. Adequate support provided to high-priority countries for improving food-safety education, effectively communicating risk, and managing public-private partnerships.	• Number of countries that have used and evaluated food-safety material based upon WHO's guidelines for safer food	2 countries per region in 2004-2005	Additional 5 countries per region

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				23 800	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

Food safety is also supported by results expected to be achieved in other areas of work, as set out below.

Area of work	Expected result(s)

VIOLENCE, INJURIES AND DISABILITIES

ISSUES AND CHALLENGES

Violence and injuries account for 9% of global mortality. Seven of the 15 leading causes of death for people between the ages of 15 to 44 years are injury-related. Children and young adolescents are also vulnerable. Injury rates vary by sex: for most types of injuries, death rates are higher for males, whereas females are at higher risk for burns, non-fatal sexual violence, or injury from an intimate partner. The burden imposed by violence and injury is particularly heavy on low-income families. The traditional view of injuries as "accidents", suggesting that they are random, unavoidable events, has resulted in their historical neglect. Research has shown that injuries are preventable; innovative, cost-effective interventions are being introduced at work, at home or on roads.

About 600 million people in the world are disabled; most of them live in poverty. The population with disabilities is increasing because of injuries from road crashes, landmines or other causes, HIV/AIDS, malnutrition, chronic conditions, substance use, population growth, or medical advances that preserve and prolong life. Less than 10% of those in need have access to appropriate rehabilitation services.

The Health Assembly recognized the need for WHO to provide support in such areas as prevention of road-traffic accidents, disabilities and rehabilitation, prevention of violence, and use of anti-personnel mines.[1] Similar resolve is expressed in such international instruments as the United Nations Millennium Declaration, the Programme of Action of the United Nations Conference on the Illicit Trade of Small Arms and Light Weapons in All its Aspects (2001), and the United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities.

The basis for WHO's activities is the *World report on violence and health*.[2] World Health Day 2004 on road safety and the *World report on road traffic injury prevention* have served as platforms to strengthen WHO's activities on road safety.[3] Both reports are starting points for tackling some of the challenges involved, but it is often unclear where responsibility lies for problems and for devising and implementing the solutions. Further, political will may be lacking because of ignorance of the magnitude of the problem or the potential for prevention. In some countries there are no focal points for injury prevention, no pertinent public-health policies or appropriate training programmes, hence insufficient resources dedicated to finding solutions.

Information systems and research are needed in order to understand better the magnitude of violence, injury and disability and their causes, together with national prevention policies and programmes, training for public health personnel, establishment of networks for advocacy and exchange of information, and better services for victims.

GOAL

To prevent violence and unintentional injuries, promote safety and enhance the quality of life for people with disabilities.

WHO OBJECTIVES

To formulate and implement cost-effective, age- and gender-specific strategies to prevent and mitigate the consequences of violence and unintentional injuries, and disabilities, and to promote and strengthen rehabilitation services.

Indicators

- Number of countries that formulated policies and prevention programmes on violence and injuries
- Number of countries that formulated policies on disabilities and implemented plans for strengthening rehabilitation services

[1] Resolutions WHA27.59, WHA45.10, WHA49.25, WHA56.24 and WHA51.8, respectively.

[2] *World report on violence and health*. Geneva, World Health Organization, 2002.

[3] *World report on traffic injury prevention*. Geneva, World Health Organization, 2004.

STRATEGIC APPROACHES Compilation and analysis of information on the magnitude and determinants of violence, injuries and disability; support for research and gathering of evidence on effective prevention strategies in developing countries, support for training and implementation of policies and strengthening of services for victims; advocacy for increased attention and a stronger focus on primary prevention; support for network development and capacity building.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Adequate support provided to high-priority countries for implementation and evaluation of information systems for the major determinants, causes and outcomes of violence, unintentional injuries and disabilities.	• Number of targeted countries that implement functional information systems on the determinants, causes and outcomes of violence, unintentional injuries or disabilities	20 countries	44 countries
2. Multisectoral interventions to prevent violence and unintentional injuries validated and effectively promoted in countries.	• Number of targeted countries that implement multisectoral interventions to prevent violence and unintentional injuries	19 countries	32 countries
3. Guidance and effective support provided for strengthening of prehospital and hospital care for persons affected by violence and injuries.	• Number of targeted countries that strengthen the response of their health-care system to violence and unintentional injuries	14 countries	26 countries
4. Effective support provided for strengthening of country capacity for integrating rehabilitation services into primary health care, and for early detection and management of disabilities.	• Number of targeted countries that implement strategies for integrating rehabilitation services into primary health care	4 countries	8 countries
5. Improved capacity in selected countries for framing policy on prevention of violence and injury or on managing disabilities.	• Number of targeted countries that have national plans and implementation mechanisms to prevent violence and unintentional injuries	16 countries	37 countries
	• Number of targeted countries that have policies on management of disabilities	90 countries	105 countries
6. Strengthened training capacity in priority countries for prevention of violence and injury and for rehabilitation services.	• Number of targeted countries that have schools of public health with training programmes on prevention and management of violence and unintentional injuries, and on rehabilitation	13 countries	34 countries
7. Functional global, regional and national networks that effectively strengthen collaboration between health and other sectors, involving organizations of the United Nations system, Member States and nongovernmental organizations, including those of people with disabilities.	• Number of global, regional and national multisectoral networks for prevention of violence and injury and for disability in place with WHO support	8 networks	11 networks

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				17 582	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

Violence, injuries and disabilities is also supported by results expected to be achieved in other areas of work, as set out below.

Area of work	Expected result(s)

REPRODUCTIVE HEALTH

ISSUES AND CHALLENGES

Reproductive and sexual health is essential for individuals, couples and families, and fundamental to the social and economic development of communities and nations. However, good reproductive and sexual health continues to elude millions of men and women in all regions of the world. Pregnancy-related complications continue to claim the lives of more than half a million women each year. Neonatal mortality (the death of a baby during the first week of life), which is closely related to women's health and care during pregnancy, has not declined over the past two decades despite the progress made in reducing infant and child mortality. Access to, and use of, contraceptives are often quoted as examples of successes in the past few decades, yet more than 120 million couples in developing countries and countries in transition still have an unmet need for safe and effective contraception. This lack results each year in 80 million unintended pregnancies, some 45 million of which are terminated – 19 million in unsafe conditions. Forty per cent of these unsafe abortions involve young women, aged 15-24 years. Complications resulting from unsafe abortions account for 13% of all maternal deaths.

Maternal and perinatal mortality and morbidity, cancers, sexually transmitted infections and HIV/AIDS account for nearly 20% of the global burden of ill-health for women, and 14% for men. In addition to the five million new cases of HIV infection and countless numbers of other incurable viral sexually transmitted infections, an estimated 340 million new cases of curable non-viral sexually transmitted infections are contracted annually. More than one million women and men die from cancers of the reproductive system, including 240 000 women, most in developing countries, from cervical cancer. In addition, there are some 2.7 million stillbirths a year, and the substantial but underestimated consequences for reproductive and sexual ill-health of sexual violence, harmful practices such as female genital mutilation, menstrual abnormalities, infertility and other gynaecological morbidities.

WHO's work on these issues is grounded in the agreements adopted at the International Conference on Population and Development (Cairo, 1994) and the Fourth World Conference on Women (Beijing, 1995) and in the commitments made in the United Nations Millennium Declaration in 2000, as confirmed by the Health Assembly.[1] It is further underpinned by internationally agreed human rights instruments and other global consensus declarations, including the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so; the right of women to have control over and decide freely and responsibly on matters related to their sexuality, including reproductive and sexual health, free of coercion, discrimination and violence; the right of access to relevant health information; and the right of everyone to enjoy the benefits of scientific progress and its applications.

The UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction is the focal point in the United Nations system for research in reproductive and sexual health.

GOAL

The attainment by all peoples of the highest possible level of reproductive and sexual health.

WHO OBJECTIVES

To ensure that by 2015 the widest achievable range of safe and effective reproductive and sexual health services is being provided across the health system and integrated into primary health care.

Indicators

- Number of countries that make reproductive and sexual health an integral part of national planning and budgeting
- Number of countries reporting at least one of the proxy indicators for use of reproductive and sexual health services

[1] Resolutions WHA48.10, WHA55.19 and WHA57.12.

STRATEGIC APPROACHES

Strengthening of the quality of care by ensuring that up-to-date practices are implemented throughout the health system; provision of evidence on causes, determinants, prevention and management of morbidity and mortality related to reproductive and sexual ill-health; identification and overcoming of obstacles to access to, and use of, reproductive and sexual health services; contribution to the empowerment of individuals, families and communities in order to increase their control over their reproductive and sexual health; creation of supportive regulatory frameworks at national and local levels; and creation of a dynamic environment of strong international, national and local support for rights-based reproductive and sexual health initiatives in order to overcome inertia, mobilize resources, and establish high standards and mechanisms for performance accountability.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Adequate guidance and support provided to improve sexual and reproductive health care in countries through dissemination of evidence-based standards and related policy, and technical and managerial guidelines.	• Number of new or updated guidance documents to support national efforts to improve reproductive and sexual health validated and disseminated in countries	None	8
2. New evidence, products and technologies of global and/or national relevance available to improve reproductive and sexual health, and research capacity strengthened as necessary.	• Number of completed studies of priority issues in reproductive and sexual health	None	40
	• Number of new or updated systematic reviews on best practices, policies and standards of care	None	15
	• Number of new research centres strengthened through grants	None	6
3. Policy and technical support effectively provided to countries for the design and implementation of comprehensive plans for increasing access to, and availability of, high-quality sexual and reproductive health care, strengthening human resources, and building capacity for monitoring and evaluation.	• Number of targeted countries with new or updated strategies and plans for strengthening access to, and availability of, high-quality sexual and reproductive health care.	20	40
	• Number of countries completing operational research studies to evaluate approaches to provision of high-quality sexual and reproductive health care	None	15
4. Adequate technical support provided to countries for better reproductive and sexual health through individual, family and community actions.	• Number of targeted countries developing new or improved interventions to foster action at individual, family and community levels for better reproductive and sexual health	None	5
5. Ability of countries to identify regulatory obstacles to provision of high-quality sexual and reproductive health care strengthened.	• Number of targeted countries having reviewed their existing national laws, regulations and policies relating to reproductive and sexual health and rights	None	3
6. International efforts for achieving international development goals in reproductive health, including global monitoring, mobilized and coordinated.	• Global report on progress towards achievement of international development goals in reproductive health submitted to the Health Assembly	1	2

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				66 435	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

Reproductive health is also supported by results expected to be achieved in other areas of work, as set out below.

Area of work	Expected result(s)

MAKING PREGNANCY SAFER

ISSUES AND CHALLENGES

Reducing the number of women dying in pregnancy and childbirth by three quarters between 1990 and 2015 is one of the targets of the Millennium Development Goals. Actions to achieve this target will also contribute substantially to reducing newborn mortality, which in turn will play an important part in the achievement of the Millennium Development Goal of reducing child deaths. Complications of pregnancy and childbirth account for the deaths of 529 000 women a year and are the second most common cause of mortality in women of reproductive age after HIV/AIDS. This burden is unevenly distributed: while the greatest numbers of maternal deaths are found in large countries with high fertility rates, the highest maternal mortality ratios are found mainly in Africa. In these areas of high maternal mortality, women run more than 140 times the risk of dying from a pregnancy-related cause than in Europe.

Since the launch of the Safe Motherhood initiative in 1987, the international community has been trying to solve this problem. A few countries have managed to reduce maternal and neonatal deaths, but mortality ratios have remained virtually unchanged in the worst affected countries. Nevertheless, important lessons have been learnt: for example, strengthening emergency care for women with complications is important but not sufficient; and training traditional birth attendants has not yielded the results expected. The WHO Making Pregnancy Safer initiative provides a set of strategy directions that build on the lessons learnt. These directions concern the establishment of an effective continuum of care for all pregnant women and their newborn infants. The continuum of care runs through all the levels of the health-care system, starting with the care provided by women, their families and communities. Critically, this requires a functioning referral system to be in place with the necessary linkages between the different levels of care, to ensure that complications, especially life-threatening emergencies, are managed quickly and efficiently. WHO's work to make pregnancy safer aims at strengthening the capacities of 72 priority countries to build this continuum of care.

Evidence of reduction in maternal and neonatal mortality, including that from case studies in Malaysia and Sri Lanka, has shown that, although poverty is an important determinant of maternal and neonatal ill-health, its effects can be overcome by improving access to, and quality of, care. In order to make these improvements, strong social and political commitment is needed. This is particularly true for actions in two areas, namely, improving the availability and utilization of skilled attendants for care throughout pregnancy, birth and the postnatal period, and providing improved health-care facilities for the management of obstetric and neonatal complications. Specific interventions and strategies for working with women, their partners and other family members and their communities have been identified in order to improve access to and use of skilled care and also to contribute to the empowerment of women and the community. Finally, strengthening health systems to ensure the continuum of care will also provide a crucial opportunity to make linkages between maternal and neonatal services and other primary health-care services such as those for HIV/AIDS, sexually transmitted infections, malaria control, family planning and child health. This area of work focuses primarily on strengthening support for countries, with related research and normative work being included in the reproductive health area of work.

GOAL

To achieve the Millennium Development Goal for maternal health by reducing maternal mortality by 75% from 1990 levels by the year 2015; and to contribute to lowering the infant mortality rate to below 35 per 100 000 live births in all countries by 2015, through a reduction in perinatal mortality.

WHO OBJECTIVES

To strengthen national efforts to implement cost-effective interventions so that health systems provide all women and newborn infants with a continuum of care throughout pregnancy, childbirth and the postnatal period.

Indicators

- Proportion of women seen by a skilled attendant at least once during the antenatal period
- Proportion of women assisted by a skilled attendant at childbirth

STRATEGIC APPROACHES Fostering of political and social commitment and effective partnerships; development and adaptation of evidence-based standards and guidelines for effective maternal and neonatal care, and provision of support to countries for dissemination and implementation; monitoring and evaluation of progress towards strategic goals and improved maternal and neonatal health; production of evidence for effective maternal and neonatal health programming; and provision of technical support to address the key interlinked elements required to build the continuum of care, namely: human resource development in maternal and neonatal health care; provision of accessible, high-quality maternal and neonatal health-care services; empowerment of individuals, families and communities to increase their control over maternal and neonatal health; and integration of other primary health-care programmes with maternal and neonatal health services.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Political and financial commitment increased through advocacy and effective partnerships promoted to provide support to countries in strengthening their maternal and neonatal health care.	• Number of recently-established joint action plans between WHO and other stakeholders at country, regional or global level	None	20
2. Technical support provided to priority countries to make the continuum of care more effective, including: developing a skilled workforce to provide maternal and neonatal health care; improving quality and coverage of maternal and neonatal health, family planning and related services; working in partnership with individuals, families and communities to increase their control over maternal and neonatal health; and integrating maternal and neonatal health service delivery and programmes for HIV/AIDS, malaria, sexually transmitted infections and family planning.	• Number of priority countries that establish plans within the biennium to improve the proportion of births attended by skilled health personnel	None	15
	• Number of priority countries that have established new mechanisms for involving individuals and communities in maternal and neonatal health programming	None	10
	• Number of priority countries where maternal and neonatal health services have initiated new collaborations with other key public health programmes	None	10
3. Evidence-based standards and guidelines for effective maternal and neonatal health care adopted by priority countries for implementation at local level.	• Number of priority countries that have recently adopted WHO standards and guidelines for maternal and neonatal health care	None	20
4. Monitoring, surveillance and evaluation systems for maternal and neonatal health programmes strengthened in priority countries and their progress towards the Millennium Development Goals monitored.	• Number of priority countries that have established a system for maternal and neonatal health monitoring and evaluation during the biennium, and for yearly reporting on key indicators	None	10
5. Capacity for conducting operational research in countries strengthened to ensure effective maternal and neonatal health outcomes.	• Number of operational research studies conducted to evaluate approaches to provision of services	None	10

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				64 150	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

Making pregnancy safer is also supported by results expected to be achieved in other areas of work, as set out below.

Area of work	Expected result(s)

GENDER EQUALITY, WOMEN AND HEALTH

ISSUES AND CHALLENGES

Differences and inequalities in socially attributed roles and responsibilities of women and men and gender-based disparities in access to resources, information and power have different consequences for women's and men's health. These factors, in interaction with other social inequalities and biological characteristics, are reflected in women's and men's exposure to health risks, access to, and use of, preventive and curative measures, health status and social consequences of ill-health.

The Platform for Action adopted at the Fourth World Conference on Women (Beijing, 1995) identified "women and health" as a crucial theme and recommended "gender mainstreaming" as the strategy for implementing actions in all critical areas of concern, including health. United Nations General Assembly resolutions and the Millennium Development Goal 3 also call for the consideration of gender to be integrated into the policies and programmes of bodies of the United Nations system and for acceleration of efforts to achieve equality between women and men.

WHO's policy seeks to integrate a gender perspective into its programmes and health-sector policies and strategies. Efforts to date have focused on building up evidence about the way gender inequality affects health; gender-based violence; gender and HIV/AIDS; and the integration of gender considerations into health research, policies and programmes. However, more work is needed to ensure that this approach becomes a core component of all public-health work.

Raising awareness and fostering partnerships between WHO, other organizations of the United Nations system, governmental bodies and nongovernmental organizations are essential. Good practices in reducing gender inequality in health systems need to be developed and documented. Capacity needs to be built in both national health systems and WHO to bring gender perspectives into the mainstream of all policies, and that integration needs to be monitored. As gender is a cross-cutting issue, political will, commitment from senior management and accountability are essential to ensuring that it is considered in all WHO's work.

GOAL

To achieve better health for girls and women, boys and men, through the promotion of gender equality between men and women, women's empowerment and the promotion of health research, policies, and programmes that adequately address gender issues.

WHO OBJECTIVES

To develop and provide support for the use of tools, strategies and interventions for the effective integration of gender considerations into health research, policies and programmes, in order to redress gender inequality and mitigate its impact on health.

Indicator

- Proportion of targeted Member States and other health partners that are using one or more WHO tools for integration of gender and women's health in the development of health policies, strategies and programmes

STRATEGIC APPROACHES

Provision of support for data collection, research, reviews and policy analysis to improve knowledge on the impact of gender inequality and roles on health and health care, and formulation of appropriate strategies; formulation, piloting and evaluation of indicators, tools and standards for the integration of gender perspectives into public-health policies, programmes and research, and for application in activities related to gender and women's health; development of skills and expansion of capacities at all levels of national health systems and within WHO to generate sex-disaggregated data, analyse them from a gender perspective and use the results to bring gender into the mainstream of health policy and programme development; advocacy and fostering of partnerships between WHO and other organizations of the United Nations system, nongovernmental organizations and other entities in order to raise awareness of, and disseminate information on, equality between men and women and health equity, with creation of intersectoral networks in countries to support this process.

ORGANIZATION WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Awareness increased and information disseminated relating to gender equality and health equity, with Organization-wide support.	• Number of networks established	Number of programmes or projects advancing gender issues in health	5
2. Information disseminated about good practices in reducing gender inequality in health and specific gender-based health risks, and provision of support to targeted countries for its use in advocacy and policy.	• Proportion of targeted countries using information about good practices in reducing gender inequality in health for advocacy, policy change or development of interventions	Number of reviews and documents available	5
3. Gender and women's health considerations incorporated into workplans of selected WHO activities.	• Number of targeted WHO programmes that systematically incorporate gender considerations in their strategies and guidelines	2	4
4. Effective monitoring tools and standards, with supporting training materials, developed and used by countries in capacity building and in design and implementation of gender-sensitive programmes and policies.	• Number of tools, standards, training and other materials developed	None	6
	• Number of targeted countries requesting technical support for using and testing training materials and standards	Current number of targeted countries requesting support	3-5 countries in each of 3 regions requesting support

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				17 800	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

Gender equality, women and health is also supported by results expected to be achieved in other areas of work, as set out below.

Area of work	Expected result(s)

CHILD AND ADOLESCENT HEALTH

ISSUES AND CHALLENGES

Newborn infants, children and adolescents make up almost 40% of the world's population; their health-related problems, and potential solutions to them, have been well documented. Nearly 11 million children under five years of age die every year – most in developing countries. The major killers remain unchanged; pneumonia, diarrhoea, malaria, measles, and HIV/AIDS cause half the deaths, with malnutrition underlying more than 50% of mortality for this group. There is a growing recognition of the particular vulnerability of newborn infants: deaths in the first month of life represent 60% of infant mortality and 40% of under-five mortality.

Cost-effective interventions are available and, when implemented on an adequate scale, they reduce child mortality significantly and improve child growth and development. Some interventions rely on properly functioning and well-supplied health services; others can be promoted through the community and civil society. However, the reach of these successful interventions is not currently sufficient to benefit those in greatest need, and should be increased.

During the coming decade, the number of adolescents in the world will rise to a record level. This group is exposed to multiple risks and multiple opportunities. Up to 70% of premature adult mortality has its roots in the adolescent period. An estimated 1.4 million adolescents lose their lives annually, mostly through injuries caused unintentionally, suicide and violence; pregnancy-related complications claim 70 000 adolescent lives a year. In addition, young people aged between 15 and 24 continue to have the highest rates of sexually transmitted infections (accounting for nearly 50% of all new HIV infections in 2002).

A set of positive factors that limit adolescents' risky behaviour has been identified. In addition to supporting the social environment of adolescents, key interventions include increasing access to age-appropriate information, skills and health services. WHO has a particular responsibility to strengthen the health sector's response to adolescent needs.

WHO has developed a number of interrelated strategies to respond to the health and development needs of children up to the age of 19 years. The strategic directions for child and adolescent health and development were endorsed by the Health Assembly; resolution WHA56.21 requests a report to be made to the Health Assembly in 2006 on WHO's contribution to implementation of the strategic directions, with particular emphasis on actions related to poverty reduction and the attainment of internationally agreed goals on child and adolescent health and development, such as the Millennium Development Goals.

Integrated management of childhood illness (endorsed by the Health Assembly in resolution WHA48.12) is a cost-effective health sector and community-based strategy that supports and complements other global initiatives to promote child survival, growth and development. The global strategy for infant and young child feeding (endorsed by the Health Assembly in resolution WHA55.25) supports interventions to improve feeding practices, reduce malnutrition, and improve growth and development. WHO's strategy for HIV and young people aims to strengthen and accelerate country-level health sector action by developing capacity, providing technical support, facilitating partnerships and mobilizing resources.

WHO continues to support strong collaboration among areas of work whose technical or population focus converges with child and adolescent health (e.g. reproductive health, making pregnancy safer, malaria, nutrition, essential medicines, and immunization). The Organization will maintain its strong partnerships with other organizations of the United Nations system, bilateral agencies, nongovernmental organizations, governments, the private sector and communities; and it will continue to guide international and national policies by means of its support to instruments such as the Convention on the Rights of the Child.

GOAL

To reduce by two thirds the rate of infant and child mortality by the year 2015 from the 1990 rate; and to reduce by 25% globally HIV prevalence among young people aged 15 to 24 years by the year 2010.

WHO OBJECTIVES

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 newborn infants, children and adolescents, and create mechanisms to measure the impact of those strategies.

Indicators

- Number of countries implementing WHO-recommended policies and programmes on neonatal and child health and development
- Number of countries implementing WHO-recommended policies and programmes on adolescent health and development

STRATEGIC APPROACHES

Elaboration of cost-effective mechanisms and guidelines to deal with diseases and conditions that represent the greatest health burden to populations; implementation of such tools in countries with feedback for further research; efforts to meet international health outcome goals by extending interventions, ensuring quality of care, and strengthening national child health programmes, particularly in countries with high under-five mortality rates; provision of support for adolescent health programming and the promotion of protective factors; prioritizing human resources, collaboration with the private sector, family and community practices, and long-term political commitment and financial support.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. 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.	• Number of countries that have initiated implementation of child and adolescent health-related recommendations resulting from WHO support to the reporting process of the Convention on the Rights of the Child	8	14
2. Improved policies, strategies, norms and standards established for protecting adolescents from disease and from behaviours and conditions that pose a risk to health, through research, and technical and policy support.	• Number of countries having developed evidence-based policy recommendations and guidelines on protecting adolescents from major diseases and from behaviours and conditions that pose a risk to health	30	40
3. Guidelines, approaches and tools put in place for intensified action towards improving neonatal and child survival, growth, and development, and monitoring of progress validated and promoted.	• Number of countries implementing integrated management of childhood illness activities and which have expanded geographical coverage to more than 50% of target districts	25	45
	• Number of WHO-supported research projects aiming to influence the formulation of strategic norms, standards and guidelines for improving neonatal and child survival	56	68
4. Contributions made to the attainment of global goals by improving child and adolescent health.	• Number of countries with child survival partnership mechanisms established to provide support for coordinated action to implement child health interventions	15	30
	• Number of countries applying the WHO strategic approach on HIV and young people	10	20

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				100 784	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

Child and adolescent health is also supported by results expected to be achieved in other areas of work, as set out below.

Area of work	Expected result(s)

IMMUNIZATION AND VACCINE DEVELOPMENT

ISSUES AND CHALLENGES

Three WHO regions (the Region of the Americas, and the European and the Western Pacific Regions) were free of poliomyelitis by the end of 2003; transmission of poliovirus continued into 2004 in the three other regions. In 2004-2005, the major effort was on interrupting transmission in all countries. In 2006-2007, surveillance efforts in the countries under the Global Polio Eradication Initiative will focus on confirming interruption of all wild-type virus transmission so that the Global Certification Commission can certify the world as poliomyelitis-free by 2008. Additionally, any reintroduced or emergent circulating polioviruses will be rapidly detected and responded to.

Despite progress, by 2004 more than 33 million children born every year did not have access to safe immunization services. Annually, vaccine-preventable diseases cause over two million deaths, mostly in the poorest countries, including an estimated 610 000 children from measles, despite the availability of a safe, effective and low-cost vaccine. Strengthening immunization services, building managerial capacity at all levels of the health systems in each district to increase and sustain access to immunization services, and surveillance of vaccine-preventable diseases continue to be the major scope of WHO's technical support to countries and regions with its partners. Within the Global Alliance for Vaccines and Immunization WHO will continue to provide high-quality technical support to improve national capacity for assuring long-term financial sustainability, including increased resources from the national budget and from donors or debt relief; the purchase of all vaccines, including new ones that are deemed cost effective; and the use of auto-disable syringes in countries' routine immunization services.

WHO's work in the development and promotion of norms and standards for vaccines, together with the existence of a functional national regulatory authority, pave the way for each country to attain the goal of using vaccines of assured quality. WHO's support to countries will continue through provision of training and strengthening of regulatory capacity and expertise.

A critical challenge remains research on, and faster development of, new vaccines. Closing the gaps in knowledge will depend on how fast WHO can harness all research efforts in order to accelerate, where possible, the preclinical development and clinical testing of new vaccines.

GOAL

To protect all people at risk against vaccine-preventable diseases.

WHO OBJECTIVES

To promote the development of new vaccines and innovation in biologicals and immunization-related technologies; to ensure greater impact of immunization services, as a component of health delivery systems; to accelerate the control of high-priority vaccine-preventable diseases; and to ensure that the full humanitarian and economic benefits of such initiatives are realized.

Indicators

- Number of poliomyelitis cases due to wild-type or vaccine-derived poliovirus
- Estimated number of measles deaths and cases globally
- Percentage of countries achieving immunization coverage of 80% with three doses of diphtheria-tetanus-poliomyelitis vaccine in all districts
- Coverage of children less than one year of age with three doses of hepatitis B vaccine

STRATEGIC APPROACHES

Monitoring and surveillance at global, regional and country levels; coordination of global research and policy development; technical and strategic support to strengthen national and district capacity to implement immunization strategies; strengthening and expansion of global partnerships.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Research supported, guidance provided, partnerships built and research and development capacity in developing countries strengthened for the development of vaccines against infectious diseases of public health significance.	• Number of early-introducers of vaccines in developing countries having taken evidence-based decisions on the introduction of vaccine against pneumococcal, rotavirus or human papillomavirus infection	6 of 34	28 of 34
	• Number of priority developing countries with improved preparedness for introduction of HIV vaccine	10 of 32	15 of 32
2. Norms and standards set for production control and regulation of vaccines and other biologicals, and reference standards established.	• Proportion of priority vaccines and biologicals for which necessary regulatory research is under way or which have production and quality-control recommendations; establishment of candidate reference materials	3 (20%) of 15 for priority vaccines and biologicals; 30% for studies on candidate reference materials from 4 WHO regions	15 (100%) of 15 for priority vaccines and biologicals; 50% for studies on candidate reference materials from 4 WHO regions
3. Capacity in countries to implement policies and to ensure that immunization programmes use vaccines of assured quality and implement safe-injection practices adequately strengthened through technical and policy support.	• Proportion of Member States in which the national immunization programme uses only vaccines of assured quality (according to WHO criteria)	179 (93%) of 192	182 (95%) of 192
	• Proportion of countries assuring sterile injection practices (according to WHO algorithm)	132 (80%) of 165 target countries	165 (100%) target countries
4. Capacity of countries to assure the security of vaccines supply and to increase the financial sustainability of the national immunization programmes adequately strengthened through technical and policy support.	• Proportion of targeted countries that have prepared and are implementing a financial sustainability plan	32 (42%) of 75	41 (55%) of 75
5. Capacity in countries to ensure effective monitoring of immunization systems and assessment of disease burden related to vaccine-preventable diseases adequately strengthened through technical and policy support.	• Proportion of Member States meeting targets for completeness of surveillance reporting from districts to national level	96 (50%) of 192	153 (80%) of 192
	• Proportion of Member States with access to accredited laboratory for testing of measles specimens	96 (50%) of 192	153 (80%) of 192
6. Access to current, new and underutilized vaccines maximized and disease-control efforts accelerated in countries and areas by the provision of technical and policy support that effectively contributes to build capacity from district level upwards.	• Proportion of the infant cohort in all Member States protected by three doses of hepatitis B vaccine	68%	84%
	• Proportion of Member States achieving immunization coverage of >80% with three rounds of vaccination against diphtheria, tetanus and poliomyelitis in all districts or at equivalent subnational administrative level	96 (50%) of 192	134 (70%) of 192

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
	• Proportion of targeted Member States having eliminated maternal and neonatal tetanus	15 (26%) of 57	28 (49%) of 57
	• Proportion of Member States achieving 90% childhood immunization coverage against measles	134 (70%) of 192	173 (90%) of 192
7. Effective coordination and support provided to interrupt circulation of any reintroduced poliovirus, to achieve certification of global poliomyelitis eradication, to develop products for the cessation of oral poliovirus vaccine and to integrate the Global Polio Eradication Initiative into the mainstream of health delivery systems.	• Number of countries and areas having reported endemic poliomyelitis during the previous three years in conditions of certification-standard surveillance	6	0
	• Proportion of countries with all laboratories containing wild-type poliovirus and vaccine production facilities meeting Biosafety Level 3 poliomyelitis requirements	53 (25%) of 215 reporting countries	215 (100%) reporting countries
	• Proportion of suspected poliomyelitis cases investigated and responded to through the Global Outbreak and Alert Response Network	25% of events	100% of events

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				382 003	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

Immunization and vaccine development is also supported by results expected to be achieved in other areas of work, as set out below.

Area of work	Expected result(s)

ESSENTIAL MEDICINES

ISSUES AND CHALLENGES

Essential medicines save lives, reduce suffering and improve health, but only if they are of good quality, safe, available, affordable and properly used. In many countries, however, not all these conditions are met. Almost 2000 million people, one third of the world's population, do not have regular access to essential medicines. Poor quality and irrational use of medicines are also causes of concern. Even when available, medicines may be substandard or counterfeit, if their regulation is weak. The use of traditional or complementary and alternative medicine, widespread in developing countries, is becoming increasingly popular in developed countries, and a source of growing expenditure globally.

The central priority remains expanding access to essential medicines, one of the health-related Millennium Development Goals to which the international community is committed. To achieve this goal and guided by the latest Health Assembly resolutions,[1] WHO will emphasize access to all essential medicines, with a focus on expanding access to antiretroviral agents to meet the "3 by 5" target. New and continued priorities in the area of medicines policies include the implementation of WHO's strategy for traditional medicine, tackling the questions of safety, efficacy, preservation and further development of this type of health care, promotion and monitoring of access to essential medicines as a human right, ensuring a public health-oriented approach to national implementation of trade agreements and promoting a stronger ethical dimension in the pharmaceutical sector.

GOAL

To help save lives and improve health by ensuring the quality, efficacy, safety and rational use of medicines, including traditional medicines, and by promoting equitable and sustainable access to essential medicines, particularly for the poor and disadvantaged.

WHO OBJECTIVES

To frame, implement and monitor national medicine policies aiming at: increasing equitable access to essential medicines, particularly for high-priority health problems and for poor and disadvantaged populations; ensuring the quality, safety and efficacy of medicines by developing international standards and supporting the implementation of effective regulation in countries; and improving rational use of medicines by health professionals and consumers.

Indicator

- Number of countries that have a national medicine policy, either new or updated, within the past 10 years

STRATEGIC APPROACHES

In collaboration with major partners, gathering and dissemination of knowledge based on experience gained in countries, and strengthening of national capability to put it into practice.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Implementation and monitoring of medicines policies based on the concept of essential medicines, monitoring the impact of trade agreements on access to quality essential medicines, and building capacity in the pharmaceutical sector all advocated and supported.	• Number of countries that have plans for implementing national medicines policy, either new or updated, within the past five years	49 of 103	62
	• Number of countries integrating flexibilities for protection of public health in the Agreement on Trade-related Aspects of Intellectual Property Rights into national legislation	32 of 105	47

[1] Resolutions WHA55.14, WHA56.27 and WHA56.31.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
2. Adequate support provided to countries to promote the safety, efficacy, quality and sound use of traditional medicine and complementary and alternative medicine.	• Number of countries regulating herbal medicines	39 of 129	47
3. Guidance provided on financing the supply and increasing the affordability of essential medicines in both the public and private sectors.	• Number of countries with public spending on medicines below US$ 2 per person per year	24 of 80	16
	• Number of countries with generic substitution allowed in private pharmacies	99 of 132	106
4. Efficient and secure systems for medicines supply promoted in order to ensure continuous availability of essential medicines.	• Number of countries with public-sector procurement based on a national list of essential medicines	84 of 127	93
5. Global norms, standards and guidelines for the quality, safety and efficacy of medicines strengthened and promoted.	• Number of international nonproprietary (generic) names assigned in the biennium	-	300
	• Number of psychotropic and narcotic substances reviewed for classification for international control in the biennium	-	4
6. Instruments for effective medicine regulation and quality-assurance systems promoted in order to strengthen national regulatory authorities.	• Number of countries operating a basic regulatory system	90 of 130	96
7. Awareness raising and guidance on cost-effective and sound use of medicines promoted, with a view to improving use of medicines by health professionals and consumers.	• Number of countries that have a national list of essential medicines updated within the past five years	82 of 114	85

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				62 285	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

Essential medicines is also supported by results expected to be achieved in other areas of work, as set out below.

Area of work	Expected result(s)

ESSENTIAL HEALTH TECHNOLOGIES

ISSUES AND CHALLENGES

Health technologies are the backbone of all health systems. Evidence-based health technologies are cost effective, meet well-defined specifications and have been validated through controlled clinical studies or rest on a widely accepted consensus by experts. They are essential tools in solving health problems. Even the most simple health system cannot function without at least some of them. Yet, most of the world's population is suffering from poverty and is denied access to adequate, safe and reliable solutions that health technologies can offer.

Some health-care technologies have only one application, whereas others are designed for multiple purposes, such as in services for blood transfusion, diagnostic imaging, clinical laboratory testing and surgery. A safe and reliable service based on these technologies relies on coherent policies and standards for safety, quality and quality control, access and use.

While developing countries face a growing diagnostic demand owing to the spread of both communicable and noncommunicable diseases, they experience a profound shortage of diagnostic-imaging, diagnostics and laboratory services. At the same time, about half the equipment available in such countries does not function because both economic and human resources are lacking.

The safety and efficacy of blood products and related in vitro diagnostic procedures rely on validated quality-assurance systems. Yet such systems are not everywhere in place: about 6 million of some 80 million units of blood donated annually are not tested in accordance with WHO recommendations on screening for infectious pathogens; inadequate safety cultures for injection, including blood-transfusion practices, cause 22 million cases of hepatitis B, 2 million cases of hepatitis C and 260 000 HIV infections. There is a clear need to strengthen national regulatory authorities and manufacturers in Member States. The decline in blood donation is another issue of concern, although the World Blood Donor Day campaign aims to encourage more people to give blood regularly.

The lack of skills to perform emergency and surgical procedures at first-referral health facilities and to implement globally-agreed practices in transplantation, including xenotransplantation, raises additional significant public health concerns.

WHO is providing support to Member States, through technical cooperation projects, to implement a number of recommendations for improving the use of essential health technologies, which are set out in basic operational frameworks.

GOAL

To strengthen the ability of national health systems to resolve health problems through the use of essential health technologies.

WHO OBJECTIVES

To establish safe and reliable services that apply essential health technologies and use biological products through the adoption of basic operational frameworks covering policy, safety, access and use.

Indicator

•

STRATEGIC APPROACHES

Development of norms, standards, guidelines, information and training material and fostering of research on essential health technologies in support of the establishment of effective health services by Member States; provision of support to Member States in establishing and optimizing the use of medical technologies; assignation of highest priority to three key initiatives that cut across these technologies: development of a list of essential medical devices, prevention of health care-associated HIV infections, and use of information technology in preventive and curative health care; performance of much of this work in association with WHO collaborating centres and other partners.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Appropriate strategies promoted and support provided for establishment of nationally coordinated blood-transfusion services with quality systems in all areas.	• Number of countries with testing of all blood donors for HIV and hepatitis B and C virus infections	106	
	• Number of countries meeting defined criteria for national coordination of blood-transfusion services with quality systems in all areas	21 countries	
2. Technical capacity of national regulatory authorities strengthened to assure the quality and safety of blood products and related in vitro diagnostic procedures.	• Number of regional networks for strengthening of national regulatory authorities for blood products involving priority countries		At least 2 regional networks will have been established and strengthened
	• Number of countries involved in WHO collaborative studies and/or using WHO international biological reference materials		10-12 countries per collaborative study
3. Technical capacity strengthened and quality and safety of, and access to, appropriate diagnostic support and laboratory services improved.	• Extent of savings made in priority countries compared to general market prices through availability of cheap but safe equipment		
	• Percentage of laboratories in priority countries with improved performances in external quality assessment schemes and other assessment tools	48%	
4. Capacity for training support to diagnostic-imaging services improved in each WHO region.	• Number of centres in each region offering training in the recommended use of radiology, including teleradiology	3 centres in 2 regions	At least 1 centre in each region
	• Number of targeted countries using the WHO manuals in training programmes	3 countries	Minimum 2 countries in each region
5. Capacity in countries for assessing national regulatory authority enhanced in the area of medical devices and development of follow-up plans.	• Number of targeted countries using the Essential Health Technology Package	6 countries	At least 1 country in each region
	• Number of targeted countries with completed assessments and follow-up plans	Nil	At least 1 country in each region
6. Appropriate support provided for use of training materials and tools to improve the technical skills of health personnel in the safe use of essential emergency procedures and equipment at first-level referral health facilities.	• Number of targeted countries using training material on surgery and anaesthesia for training health providers at district hospitals	Training material on surgery and anaesthesia (in preparation)	At least 2 countries in each WHO region

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
7. Effective guidance for formulation of national policy and legislation provided in order to assure the ethics, safety and quality of cell-tissue and organ-transplantation practices.	• Number of targeted countries using WHO core standards as a basis for national transplantation standards		10% of targeted countries in each region
	• Number of targeted countries with access to basic transplantation	Nil	10% of targeted countries in each region
8. Standardized procedures for development of WHO model lists of essential medical devices validated and disseminated.	• Number of interested parties that have adopted WHO model list of essential medical devices	Nil	Standard procedures adopted by at least 4 technical WHO list producers
	• Number of WHO thematic lists of devices updated and refined	Nil	At least 4 thematic lists refined, available and in use
9. Appropriate strategies promoted and support provided for an effective system for prevention of health care-associated HIV infection.	• Number of targeted countries using model list of essential infection-control equipment and supplies	Nil	At least 1 country in each region
	• Number of targeted countries with an effective system for prevention of health care-associated HIV infection	21 countries	At least 33 countries
10. Establishment of appropriate components of electronic information for use in health-care systems promoted and effectively supported.	• Number of countries adopting national policies on use of electronic information in support of health care		At least 10 countries
	• Number of countries using guidelines for applications of electronic information for health-care delivery		At least 10 countries applying electronic information for health-care delivery

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				31 328	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

Essential health technologies is also supported by results expected to be achieved in other areas of work, as set out below.

Area of work	Expected result(s)

POLICY-MAKING FOR HEALTH IN DEVELOPMENT

ISSUES AND CHALLENGES

The way in which WHO seeks to influence a wide range of national and international policies, laws, agreements and practices has an impact on the functioning and effectiveness of health systems and the achievement of health outcomes. It reflects WHO's concern for human dignity, security, ethics, equity and social justice, and the need to maximize health opportunities by tackling social and economic barriers to health and health care. Work in this area will contribute to progress towards better health, poverty reduction, greater health equity and achievement of the relevant Millennium Development Goals and other internationally agreed development goals.

The Millennium Development Goals provide an important opportunity to promote the incorporation of health priorities in national and international development processes (including those concerned with poverty reduction). The challenge for WHO is to translate this opportunity into policies and strategies that will increase health investments, focus on the poor and reduce health inequities, and to build institutional capability – both in national governments and in WHO's country offices – for their implementation. A further challenge will be to identify macro-level or national policy implications for the health sector from community-based work under way in many regions.

GOAL

To maximize the positive impact of processes related to socioeconomic development, poverty reduction and globalization on health outcomes; to raise awareness and advocate the role of better health, particularly of the poor, in achieving overall development objectives; and to bring ethical, legal, and human rights norms into the formulation of national and international health-related programmes, policies and laws.

WHO OBJECTIVES

To maintain and further secure the centrality both of health to a wide range of development processes at national, regional and international levels, and of ethical, economic, and human-rights analysis to the achievement of just and coherent policies and laws at national, regional and international levels.

Indicators

- Recognition of the role of health in national development in political and development forums, and its translation into policies, plans and budgets at country level
- Recognition of ethics, law, trade and human rights in WHO consultations and in political forums, and their translation into policies, plans and action at country level

STRATEGIC APPROACHES

Provision of guidance, advocacy and technical support to countries on such issues as the relationship between health and human rights, poverty, aid instruments, macroeconomics, equity, ethics, globalization, trade and law; ensuring reflection of recommendations of national and international bodies in these areas in national development policies, plans and budgets and linkage between community-based initiatives in which WHO is involved into national policy; ensuring the capability of WHO – particularly through country offices – to provide support in these areas, through the development of policy, guidance and direct support; convening of bodies of experts and/or policy-makers at national and international levels to build consensus around different aspects of health and development, and to advance understanding and knowledge of the issues covered; commissioning and conduct of research and analysis that will inform decision-makers in ways that are congruent with WHO's overarching objective; assuring focus of WHO's contribution and leadership on achievement of the health-related Millennium Development Goals and other internationally agreed development goals.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Strengthened country capacity to ensure that national development plans and budgets, Poverty Reduction Strategy Papers, public sector reforms and sector programmes (including sector-wide approaches) and intersectoral mechanisms support increased investments in health and improved health outcomes, including achievement of the health-related Millennium Development Goals, and focus on the impact of any proposed measures on poor, vulnerable and marginalized people.	• Proportion of low-income countries in which WHO has played an acknowledged role in enabling national authorities to develop Poverty Reduction Strategy Papers, national poverty reduction plans, sector programmes that include a coherent and costed approach to health of the poor • Proportion of low-income countries in which WHO has made an acknowledged contribution to assessing equity in the preparation of national health plans	Less than 10% of eligible countries	50% of eligible countries
2. WHO fully engaged in global dialogues and dissemination of best practices and processes on development, particularly in relation to the Millennium Development Goals and other partnership-based mechanisms with the aim of integrating health in the mainstream of development activities, increasing resources, and improving the effectiveness and equity of aid-delivery mechanisms in the health sector.	• Increase in the aid-effectiveness score (devised by OECD's Development Assistance Committee) in poor countries • Increase in resources available to the health sector in low-income countries		
3. Endorsement by WHO's governing bodies of the recommendations of WHO's commission on equity and social determinants of health and adoption by countries.	• Number of country programmes and activities that include in their operations recommendations of WHO's commission on equity and social determinants of health • Number of WHO programmes that adapt their day-to-day operations on the basis of insights provided by WHO's commission on equity and social determinants of health		
4. Implementation of WHO's strategy on health and human rights initiated in order to advance globally the concept of health as a human right; capability strengthened at regional level to provide support to Member States for integrating a human-rights approach into health-related policies, laws, and programmes.	• Extent of progress in implementing WHO's strategy on health and human rights	WHO's strategy on health and human rights formulated	Approval of the strategy on health and human rights by WHO's governing bodies

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
	• Number of national partnerships forged, tools made accessible, and projects under way to integrate a human-rights approach into health development	4 global tools available to regions and countries	Staff tools and training available in 3 regional offices to support countries in implementing WHO's strategy on health and human rights Implementation of the strategy under way in 3 countries in each region
5. Increased capacity at country, regional and global levels and within the Organization to measure, assess and act on cross-border risks to public health in the context of globalization, focusing on implications for population health of multi- and bi-lateral trade agreements.	• Extent of capacity to assess and act on health implications of trade and globalization	Number of countries with ministerial mechanisms for trade and health Staff time in regions dedicated to issues related to trade and health	4 countries in each region with active interministerial mechanisms for trade and health Half-time trade and health adviser in 4 regional offices
6. Support provided at the three levels of the Organization for analysing the ethical aspects of health and research; support provided to countries through tools, standards, and guidelines for incorporating an ethical analysis into health services delivery, research and public-health activities.	• Number of global and regional programmes and activities that include ethics in plans, activities and products	5	10
	• Extent to which countries integrate ethics into health programmes and policies	A few topics addressed in some countries	More topics addressed in a larger number of countries
7. Strengthened capacity of Member States to formulate and implement legislation and regulations to protect and promote public health, through technical cooperation and information exchange at country, regional and global levels.	• Number of global and regional programmes and activities that include a health-law component • Extent to which countries formulate health law to meet contemporary public health priorities		

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				37 651	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

Policy-making for health in development is also supported by results expected to be achieved in other areas of work, as set out below.

Area of work	Expected result(s)

HEALTH SYSTEM POLICIES AND SERVICE DELIVERY

ISSUES AND CHALLENGES

It has become increasingly evident that in many countries a vast array of effective interventions are not being provided and delivered, as a result of problems related to both access and quality of care. The impetus given by the Millennium Development Goals and growing interest in the health sector in general has led to a remarkable increase in disease-specific programmes implemented by both international organizations and national bodies.

This trend is creating new and complex challenges to health systems. Although these programmes are leading to considerable innovation and experimentation in strategies to increase coverage for specific diseases, governmental institutions responsible for the overall organization of the health sector are not being reinforced. Consequently, it has become necessary to understand and align better health-system planning with disease-specific initiatives in countries, and urgent for governmental institutions to exercise their steering function and ensure overall coherence of their health systems based on principles of primary health care.

This reinforcement is needed at several levels. At policy level there should be sufficient governance and regulatory capacity for governments effectively to exercise their steering role in the growing heterogeneity of most health systems. They need to play their part as "stewards" and maintain an overview of the entire health system; to plan and regulate coherently public and private delivery of health services; to ensure that public health functions are strengthened as well as health services; and to detect and counterbalance developments that will impact negatively on more vulnerable groups.

At managerial levels such as subnational, district and institutional levels a massive reinforcement of capacity is needed in order to handle the increasing complexity of health-care delivery and boost efforts to promote health, prevent disease and improve quality of care.

In this context Member States are increasingly requesting WHO to cooperate directly in their strategic policy-making, to establish a sound basis for those policy discussions by providing advice and guidance on the wide range of issues related to health-system organization, management, and financing, human resources, and information systems for health services. Such guidance needs to be adaptable to heterogeneous situations and both public and private health systems. In some countries the main issue will still be one of coverage and basic delivery, whereas in others there may even be excess capacity and inappropriate use of services. The challenge is therefore one of restructuring delivery in order to improve quality and efficiency.

GOAL

To improve the availability, quality, equity and efficiency of health services by strengthening their links with the broader public health functions and by strengthening the governance, organization and management of health systems.

WHO OBJECTIVES

To strengthen health-system leadership and capability for effective policy-making in countries, and to enhance the planning and provision of health services that are of good technical quality, responsive to users, contribute to improved equity through greater coverage, and make better use of available resources.

Indicators

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STRATEGIC APPROACHES

Strengthening of WHO's support to countries for framing health-sector policy and implementing change, through more systematic collaboration in national strategic planning, health-system reform and interinstitutional coordination, in collaboration with other development organizations, and for reinforcing efforts to improve health service delivery, through analysis of constraints, and informed advice on innovative strategies for expanding or restructuring health services by improving the organization and management of different providers; guidance on different models of care which take into account the need for integrated health services across health institutions, and which ensure a continuum of care for patients; projects that strengthen consumer and patient involvement as active players in health-system development and service delivery, particularly on quality of care and patient safety; effective integration at country and international levels of health-systems work with disease-specific programmes in order to ensure better alignment between support to health system development and the more focused efforts to improve delivery of specific health interventions.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Guidance prepared and technical support provided to improve country capacity in national and local health-sector policy-making, regulation, strategic planning, implementation of reforms, and interinstitutional coordination.	• Proportion of low-income countries in which WHO has played a key role through collaborating directly in redesigning health-sector policy	Estimated number of countries having received direct policy support in 2004-2005	Double number of countries having received support for health-system policy-making
2. Organized approach developed for WHO's collaboration in health-sector reviews in countries, including an Internet-based mechanism for continuous provision of health-systems policy support; number of new, evidenced, knowledge-based policy briefs increased; strategies formulated for capacity building in health policy.	• Number of countries using Internet briefs effectively for policy dialogue • Number of WHO country office staff trained in strengthening of health systems	Internet-based mechanism with Organization-wide policy briefs	Internet-based mechanism for policy dialogue in use in 20 countries Double the number of WHO country office staff trained in strengthening of health systems
3. Guidance and technical support provided on improved alignment of population-based public health policies and health service policies.	• Extent of review of best practice for preparation of advice and guidance on integrating public health in health services, and on engaging public-health institutions	Existing guidance on integrating public health in health services	Engagement of 20 international public-health associations; new approaches to training in public health in use in 10 leading public-health schools
4. Evidenced, knowledge-based guidance and technical support provided to countries for strengthening delivery of health services centred on quality, equity and efficiency.	• Number of WHO regions in which the renewed framework for health systems based on the principles of primary health care has been adapted, and support to countries initiated • Number of pilot experiences on integrated care in less developed countries	Existing advice on application of the renewed framework for health systems	

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
5. Guidance and direct technical support provided to countries on effective integration of health services with disease-specific programmes.	• Adequacy of guidelines, norms and tools for improved articulation between disease-specific programmes and health services	Existing strategies for articulation between disease-specific programmes and health services	Acceptance by WHO's governing bodies of a framework for the effective integration of health services and disease-specific programmes; use of that framework in at least 10 countries

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				124 597	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

Health system policies and service delivery is also supported by results expected to be achieved in other areas of work, as set out below.

Area of work	Expected result(s)

HUMAN RESOURCES FOR HEALTH

ISSUES AND CHALLENGES

There is an increasing recognition that to scale up major health interventions, provide good-quality services, and achieve the health-related Millennium Development Goals requires a health workforce that is sufficient in numbers, appropriate as to profiles, well educated and trained, and adequately deployed, managed and motivated. Furthermore, financial resources cannot be translated into more and better health services unless recipient countries can count on a functional workforce. Without a better understanding of the human-resources component of health systems, health-sector reform cannot be effective or sustainable. This component needs to be an integral part of health and development strategies such as poverty reduction and macroeconomic reforms.

The most crucial issue facing health systems is failure of domestic labour markets, resulting in a range of problems from absolute shortage, to underemployment, to oversupply. Migration of health personnel has considerable consequences for countries with small populations or health-system constraints. To tackle such problems, countries require strategies that focus on better alignment of education to practice, increase the motivation and productivity of health workers, identify underlying reasons for retention of personnel, and improve recruitment practices. Implementation of these strategies needs action at different levels and with different timeframes. At national level, weak information systems on human resources need to be strengthened and mechanisms put in place to facilitate dialogue and cooperation between different ministries and the public and private sectors. They way in which development partners undertake activities related to human resources for health in a country should be more closely aligned to its needs. At international level, there is a need to take account of, and begin to act on, macroeconomic policies that have an impact on national health workforces, especially because the market for skilled health workers is global. This requires the development of strategies that actively engage IMF, the World Bank and WTO in seeking solutions outside current thinking.

To meet the challenges faced by countries and achieve necessary changes, significant investments are needed. These include investments to strengthen institutions that educate and train the health workforce; to build capability of ministries of health to manage their health-workforce issues; to improve the ability of regulatory systems to ensure quality of providers; to address issues of equity, gender, skill mix and distribution; to construct networks that will share best practices and support implementation; and to promote research in human resources for health so as to improve the knowledge base.

Tackling crucial issues of delivery such as HIV/AIDS treatment, responding to epidemiological and demographic changes, and assuring services in countries affected by conflict will require close attention to a broad range of health workers, from the specialist to the person providing support in the home. Training and education of health workers should be aligned with such delivery systems as primary health care and compatible with the strengthening of public health systems in the context of new actors and institutional arrangements. Further, countries need to find mechanisms to work with the growing number of stakeholders in the private not-for-profit and for-profit sectors.

GOAL

To improve the performance of health systems through strengthening development and management of the health workforce in order to achieve greater equity, coverage, access and quality of care.

WHO OBJECTIVES

To contribute to managing effectively and creatively the interaction between the supply and demand for health workers.

Indicators

- Successful retention of an expanded health workforce in countries, reprofiled to meet health needs
- Strengthened national capacity for policy framing and management of the health workforce

STRATEGIC APPROACHES

Development of guidance and best practices to support policy formulation and implementation by linking policy frameworks for human resources with other aspects of health-services delivery and health-systems development, starting with those areas in which WHO is providing support; design of activities through country dialogue; implementation led by countries, focused on solutions, and built upon existing information and policy-making processes.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Guidance and support provided for effective analysis, planning and management of the health workforce in countries.	• Number of countries using WHO human-resources planning and management guidelines	According to surveys to be carried out in 2005	At least 20 more countries
	• Number of countries using evidence-based tools to improve recruitment and retention of health workers	According to surveys to be carried out in 2005	At least 20 more countries
2. Strengthened leadership, policy-making, public health, management and research capacities.	• Number of countries in which WHO actively demonstrates institutional capacity for supporting leadership	According to surveys to be carried out in 2005	At least 15 countries
	• Number of networks established to support research and leadership in public-health education in human resources	4 at the start of the biennium	1 more established in each region
	• Functioning health leadership programme	At least 35 officers enrolled	At least 30 more officers enrolled
3. Strategies to reduce the outflow of health workers promoted.	• Number of countries with policies and strategies designed to reduce the outflow of health workers	According to surveys to be carried out in 2005	At least 25 countries
4. Practical guidance and tools to ensure quality of education and training and its relevance to needs available to countries and used in targeted countries.	• Number of countries in which WHO supports assessment of education of health professionals, including evaluation of training programmes and review of curricula	According to surveys to be carried out in 2005	20 more countries
	• Number of targeted countries in which tools, guidelines and methods for improving quality and standards of training and education of health professionals are used	According to surveys to be carried out in 2005	50 countries
5. Strengthened institutions and processes that will increase capacity for research on human resources for health in countries.	• Number of institutions in developing countries with an active research programme on human resources for health	According to surveys to be carried out in 2005	At least 30 active programmes
6. Effective guidelines on accreditation, licensing and certification to support mechanisms and frameworks that ensure good-quality preparation and practice of health professionals made available to countries and in targeted countries.	• Number of targeted countries with functioning regulatory mechanisms	According to surveys to be carried out in 2005	20 countries
7. Regional alliances and networks set up involving development partners, professional organizations and other institutions to address macroeconomic processes that have an impact on the health workforce.	• Number of alliances and networks established	1 global, 0 regional	At least 2 regional alliances

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				76 838	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

Human resources for health is supported by results expected to be achieved in other areas of work, as set out below.

Area of work	Expected result(s)

HEALTH FINANCING AND SOCIAL PROTECTION

ISSUES AND CHALLENGES

The way the health system is financed and organized is a key determinant of population health and well-being. Health financing has become a central issue to many governments as they seek to improve their health systems, with policy debates covering the questions of how funds should be raised, how they should be pooled to spread risks, and how they should be used to provide the services and programmes needed by their populations. In some regions, the level of spending is still insufficient to ensure equitable access to basic and essential health services and interventions, so the major concern is to ensure adequate and equitable resource mobilization for health. In some countries within these regions, external sources have recently provided substantial increases in resources for selected health interventions, leading to increased attention focused on how to sustain such increased expenditure over time. In other settings, health costs have been rising rapidly and a dominant concern is to reduce the rate of growth of health expenditure while maintaining the quality of the health system. Fragmentation of pooling arrangements and passive purchasing methods that generate inappropriate incentives for providers are characteristic of many countries. As fragmentation is also a constraint on the potential to cross-subsidize from the rich to the poor and from the healthy to the sick, many financing systems do not provide adequate levels of social protection. All countries are concerned with ensuring that the resources available to health are used efficiently and that they are distributed equitably, yet disparities in access to services between rural and urban areas and between the sexes remain in many settings. In all but a handful of countries, health financing heavily relies on out-of-pocket payments, placing large, sometimes catastrophic, financial burdens on households who can be pushed into poverty, or further into poverty, as a result. Moreover, the need to make such payments prevents people, especially those who are poor, from obtaining necessary care.

Incomplete data and information on the level and distribution of health expenditures hinder policy analysis, as does a lack of information on the effectiveness, and the costs and implications for equity, of different ways of using scarce resources. Many countries do not have sufficient skills in budgeting, financial planning and management, which impedes their potential to maximize health gains from available resources. International experience on the impact of different health-financing reforms has not yet been adequately reviewed and the information made readily available to policy-makers in a form they can use. The challenge is to work with countries and the variety of other partners working in the area of health-system financing to develop ways of obtaining key information, to use it as an input to the debate on policy and its implementation to improve health systems, and to build capacity to obtain and apply this information.

GOAL

To develop systems of health financing that are equitable, efficient, protect against financial risk, promote social protection and can be sustained over time.

WHO OBJECTIVES

To formulate health-financing strategies based on principles of equity, efficiency and social protection, and on the best available information and knowledge; to develop capacity to obtain key information and to use it to improve health financing and organizational arrangements as part of national policy.

Indicators

•

STRATEGIC APPROACHES

Provision of policy support to countries in accordance with country needs; development of tools, information and knowledge to support policy dialogue and implementation; building of institutional, organizational and human capacity in collaboration with countries; provision of opportunities to share national and international experiences, evidence and best practices in implementing various financing and social protection options; development of partnerships with international and national institutions, and governmental and nongovernmental organizations.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Consistent policy options, guidelines and recommendations on health financing and social protection developed and used in countries.	• Availability of policy options and guidelines on key dimensions of financing and social protection policy, priority-setting, and ways of reducing the risks associated with out-of-pocket payments	14 policy-issue papers on financing and social-protection policy, contracting, priority-setting and use of cost-effectiveness analysis, cost of expanding interventions	Additional 8 policy-issue papers on financing and social-protection policy, contracting, priority-setting, use of cost-effectiveness analysis, financial cost of expanding interventions, nonhealth benefits of interventions
	• Extent of the use of these policy options, guidelines and recommendations in countries to improve the social protection, efficiency and/or equity of their financing systems	Use of policy papers in 10 countries, including by established commissions on macroeconomics and health and in sector-wide approaches in selected countries	Use of policy options, guidelines and recommendations in 17 countries, including by established commissions on macroeconomics and in sector-wide approaches in selected countries
2. Information on best practices with respect to financing and social-protection policy, priority-setting and generation of key information provided to countries, and its use supported.	• Availability of policy briefs on key questions in health financing, social protection and priority-setting in a form that is readily accessible to policy-makers	8 policy briefs available; no existing comparative case studies on priority-setting and insurance reimbursement	14 policy briefs available. Comparative case studies on priority-setting and insurance-reimbursement decisions
	• Extent of use of policy briefs in national policy debate and to guide policy implementation	Use in 10 countries, including in policy debate on financial-risk pooling	Use in 17 countries, including in policy debate on financial-risk pooling and social protection
3. Key tools, information and knowledge to guide policy framing and implementation validated and their use supported.	• Availability of practical guides on national health accounts and resource tracking; availability of tools to describe and analyse arrangements for collection, pooling and purchasing, and associated issues of system structure, to help in setting priorities for available and new resources and to expand key interventions, to determine the extent and nature of financial risks and catastrophic expenditures, and to assess options to reduce financial risks and expand social protection	First version of tools on financial implications of financing arrangements, contracting, country contextualization for priority-setting, cost of expanding interventions; no existing tool for estimating nonhealth benefits of interventions	Improved tools on resource tracking, impact of financing arrangements and out-of-pocket payments, contracting, country contextualization for priority-setting, cost of expanding interventions; new tool for estimating nonhealth benefits of interventions

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
	• Extent of use of tools, guides and knowledge in countries	Use of tools for resource tracking, calculating financial risks to households, financing and contracting in 20 countries; country contextualization for priority-setting undertaken in 4 countries; integrated costing tool used in 4 countries; database available on effectiveness and costs of 300 interventions; no existing estimates of nonhealth benefits; annual reporting of summary ratios of health expenditures	Use of tools for resource tracking, calculating financial risks to households, financing and contracting in 30 countries; country contextualization for priority-setting undertaken in 12 countries; integrated costing tool used in 12 countries; database available on the effectiveness and costs of 400 interventions; estimates of nonhealth benefits available for 6 countries; annual reporting of summary ratios of health expenditures
4. Strengthened country capacity to obtain information and use it to formulate plans and policies and guide interventions for improving systems of health financing and social protection.	• Number of countries or regions benefiting from training programmes, conducted in collaboration with partners, on the use of the tools and guidelines; analysis of the results, followed by policy dialogue	Training courses on national health accounts, priority-setting, costing, and catastrophic expenditures in 2 regions per year; training courses on implications of health financing and contracting in 5 countries	New training courses on national health accounts, priority-setting, costing, risk protection and catastrophic expenditures in 2 regions per year; training courses on implications of health financing and contracting in 8 countries
	• Existence of working networks of technical experts established for priority-setting, costing and cost-effectiveness	2 working networks on national health accounts	At least one working network on costing, cost-effectiveness, and financing policy, with participation of all regions

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				40 109	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

Health financing and social protection is also supported by results expected to be achieved in other areas of work, as set out below.

Area of work	Expected result(s)

HEALTH INFORMATION, EVIDENCE AND RESEARCH POLICY

ISSUES AND CHALLENGES

Sound health information is the essential foundation of public health programmes, aiming to promote greater equity in health between and within populations. In many countries, and most particularly those with the highest burden of disease, however, basic systems are not in place for counting births and deaths, identifying cause of death, monitoring health status, or tracking use and effectiveness of programmes. Programme planners and managers do not have the information they need to use resources effectively, and at the same time are beset with demands from external agencies to provide data for monitoring the use of their funds. There is an urgent need to reform and strengthen the building of health information systems, including surveys, vital registration, surveillance and service statistics, as a joint effort between health and statistical constituents that can meet the needs of both planners and managers and donors at country and global levels. WHO will play a key coordinating, operational and technical role in this process, including in reporting on progress in achieving the health-related Millennium Development Goals.

WHO has the constitutional mandate to establish and revise as necessary international classifications for diseases, causes of death and other public health parameters. The *International statistical classification of diseases and related health problems* and the *International classification of functioning, disability and health* are the two principal reference classifications. The main challenges are to enhance the access to, and use of, the classifications, especially in developing countries, and to work on revisions in close collaboration with WHO collaborating centres.

Health information and evidence should play a major role in directing resource flows and health programmes at country, regional and global levels. WHO plays a unique role in generating and consolidating knowledge and evidence on public health issues, including the publication of comparative and analytical reports and the promotion of multicountry studies on key public health topics. Failure to put existing and new knowledge rapidly into practice, in the broader context of building health systems, is a key challenge for the health-research community. The response calls for tackling the inequity that exists in access to health information and knowledge, and assuring that knowledge derived from research is accessible, disseminated and shared between the producers and users of research.

Such action requires a strong national health-research system based on a favourable enabling environment for research and for collaboration with regional and global research systems. Through its close interaction, mutual learning and integration within the health system, health research that is a tool enables countries to analyse, understand and operate the health system in an efficient manner. An effective and accountable health system must, among other features, be able to link research to health policy, put evidence into the practice of health-care delivery, and obtain people's support for, and participation in, the research endeavour.

Research aimed at improving the health system is the means through which knowledge is translated and applied to building better health systems but is a relatively neglected area compared to the huge investments made in the biomedical and clinical sciences. This imbalance needs to be corrected in order to make effective use of scientific knowledge to inform policy for improving health and health equity. WHO will play a leadership role in this regard in close collaboration with other organizations involved in health research, such as the Council for Health Research for Development and the Global Forum for Health Research. WHO will also play its part in institutional strengthening in countries through, for example, its network of collaborating centres, and in promoting a broader, multisectoral and cross-cutting view of health research which includes the social sciences, such as economics, demography, and behavioural sciences.

GOAL

To maximize the potential of health systems to improve health and to respond to health needs in a way that is equitable, effective and efficient on the basis of sound health information and scientific knowledge.

WHO OBJECTIVES

To improve the availability, quality and use of health information at country level; to strengthen the evidence base at regional and global levels in order to monitor and reduce inequalities in health; to develop health-research systems, to build research capacity, and to use research findings to strengthen national health systems.

Indicators

- Production and use of accurate and timely health information in countries
- Ability of countries to report on the key health-related Millennium Development Goals
- Level of resources mobilized compared to the funding gap
- Equity of access to knowledge and health information

STRATEGIC APPROACHES

Support for reform and strengthening of country health-information systems, including focus on the subnational level, use of data, and development and implementation of locally relevant tools; development and enhancement of the evidence base for health systems, by consolidation and publication of existing evidence and facilitation of knowledge generation in priority areas; global advocacy and promotion of health research to build better health systems; dialogue and coordination with interested partners at national, regional and global levels, in order to develop relevant activities and initiatives; fostering of cooperation between countries and regions to promote research and knowledge sharing; policy, technical and analytical activities in countries to strengthen health research and its interface with health systems at national and subnational levels; setting of standards of ethical conduct in health research; greater lay-public involvement in knowledge access and sharing for the right to better health.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Strengthened and reformed country health-information systems that provide and use quality and timely information for local health problems and programmes and for monitoring of major international goals.	• Number of countries with adequate health-information systems in line with international standards	Number of countries currently meeting the standard	25 additional countries making significant progress towards achieving the standard for a sound health-information system
	• Number of countries adapting or using specific materials and tools, such as the *International statistical classification of diseases and related health problems* and the *International classification of functioning, disability and health*, and reviews of health status and health-systems metrics	Number of countries currently using specific materials and tools	At least 10 additional countries using specific materials and tools
2. Better knowledge and evidence for health decision-making, by consolidation and publication of existing evidence and facilitation of knowledge generation in priority areas.	• Existence of a WHO database of core health indicators with metadata, focusing on health-related Millennium Development Goals	Partly harmonized databases in regional offices and headquarters	Harmonized and consistent high-quality databases with metadata available and well used
	• Number of areas in which WHO's work has generated new evidence to redirect health programmes or reinforce existing priorities	Number of key areas in which WHO needs to generate new evidence through generation or consolidation of evidence	All priority areas addressed through, for example, analytical reports, or comparative analyses

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
3. Strengthened national health research for health-systems development, within the context of regional and international research and engagement of civil society; WHO programmes and initiatives in research for health-systems development and for access to, and use of, knowledge effectively developed and implemented on the basis of strategic priorities.	• Number of targeted countries and collaborators using or adapting WHO guidelines and tools for analysis and strengthening capacity of national health-research systems	10 to 15 developing countries having updated their strategies for strengthening national health-research systems using WHO guidelines and tools	10 to 25 targeted developing countries updating health-research strategies and applying WHO tools
	• Availability of a core set of health-system research priorities for WHO	Draft framework of priorities	Final list of priorities
	• Effectiveness of WHO global programme in research for health-systems development	Draft plan for programme	Programme launched and implemented in all regions
	• Existence of initiative to build capacity in research consolidation in countries	No coordinated initiative in place	Initiative implemented in selected countries
4. WHO-led networks and partnerships established that improve international cooperation for health research, including an effective ACHR at global and regional levels, WHO collaborating centres and expert advisory panels.	• Functionality of mechanisms such as the Partners' Forum to promote strong partnerships and synergy between key organizations at global level	Minimal coordination, independent activities	Effective mechanisms for partnerships and coordination of activities between key organizations
	• Coverage of the network of national task forces on health research and health systems, that work in close cooperation with WHO global, regional and country counterparts	10 to 15 national task forces on health-research systems established in targeted countries	10 to 20 additional national task forces on health research and health systems developed in targeted countries
	• Extent of networking between WHO collaborating centres in high priority areas	Several networks in high-priority areas	Larger number of networks in high-priority areas
	• Effectiveness and impact of WHO's policy for collaborating centres	Draft of new policy agreed by all regions	New policy fully implemented
5. Guidelines and standards determined that ensure ethical conduct of health research and best practices disseminated within WHO.	• Level of harmonization of ethics review procedures at headquarters and regional offices	Standard ethics review procedures established at headquarters	Ethics review procedures harmonized at headquarters and in the regions

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				55 744	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

Health information, evidence and research policy is also supported by results expected to be achieved in other areas of work, as set out below.

Area of work	Expected result(s)

EMERGENCY PREPAREDNESS AND RESPONSE

ISSUES AND CHALLENGES

Crisis conditions now affect communities in more than 40 countries, and as many as 2000 million people are at risk because food, water, sanitation, security and health systems have collapsed or are overwhelmed. There is a marked increase in natural disasters, with an estimated 608 million people affected. Weather-related disasters are on the rise. In 2003 there were 10 million refugees, and 25 million internally displaced persons worldwide.

The quest to realize the Millennium Development Goals can only be fulfilled if attention is paid to the health aspects of crises. Vulnerable groups bear the highest rates of distress, as their coping mechanisms are already weakened. But the main causes of suffering and death are sicknesses – principally common conditions made more dangerous by crisis conditions – and the breakdown in public health.

The Health Assembly had requested WHO to undertake a number of steps to strengthen emergency preparedness, disaster reduction, emergency response and humanitarian action,[1] and recently requested it to provide support for strengthening health systems with regard to emergency preparedness and response plans.[2]

WHO therefore plays a key role in ensuring adequacy of preparedness programmes, reliable assessment and analysis of needs, and an effective, coordinated response to health aspects of crises. Within the United Nations system, WHO – focusing on the health and well-being of all people – assumes this role in advocacy, resource mobilization and direct, life-saving, action. This work is undertaken in conjunction with national authorities, nongovernmental organizations, organizations of the United Nations system and development banks.

WHO makes a critical contribution to the repair and recovery of local health systems, linking them with support from outside and concentrating on reducing vulnerability and promoting equity. It also helps identify vulnerable elements of health systems and ensure that they are promptly strengthened.

Predicting resource requirements and availability is based on past trends. Taking into account the amount WHO will appeal for under United Nations consolidated and ad hoc appeals during the biennium and funding in support of implementation of a performance-enhancement programme, it is estimated that extrabudgetary resources totalling US$ 175 million can be mobilized. The budget estimates of US$ 106.8 million below reflect only expenditure that with some degree of certainty can be predicted globally. It is not possible to predict in which regions the remaining balance of some US$ 68.2 million will be expended.

GOAL

To reduce avoidable loss of life, burden of disease and disability among populations affected by crises, emergencies and disasters, to optimize health at times of post-crisis transition, and to contribute to recovery and development.

WHO OBJECTIVES

To develop and implement policies, programmes and partnerships that increase the capacity to prepare, respond and mitigate the risks to health during crises, and support recovery and sustainable development.

Indicator

- Adequacy of national disaster-reduction policies, and plans for response and recovery

STRATEGIC APPROACHES

Establishing and operationalizing a system for improving WHO's performance, involving strengthened human and material capacity at country level; development of institutional knowledge and competence through performance monitoring and technical guidance; and dedicated rapid-response mechanisms, throughout Member States, at WHO country offices, with support of regional offices, at headquarters, and in WHO collaborating centres.

[1] Resolution WHA48.2.

[2] Resolution WHA55.16.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Operational presence in countries strengthened in order to collaborate with Member States and stakeholders in preparing and responding to the health aspects of crises and in formulating and implementing recovery, rehabilitation and mitigation policies.	• Number of countries with preparedness, response and mitigation programmes in place • Number of WHO country offices meeting agreed standard performance level for health action in crises • Percentage of crises in which preparedness measures were taken and adequate response was given, in accordance with agreed levels		
2. Global synergy and local effectiveness fostered through enhanced mechanisms for internal and external coordination on technical, administrative and logistic issues, performance monitoring, and development of institutional knowledge and competencies, that enable Member States and stakeholders to deliver the required action in the various stages of crises.	• Number of health updates, guidelines and technical publications produced, updated and disseminated on all areas covered by WHO's standard performance in crises		
3. Resources mobilized and systems established to permit a rapid and dependable response that emphasizes the health priorities of populations at risk of, or affected by, natural disasters, complex emergencies and protracted crises.	• Resources made available for proper pursuit of priority health-sector outcomes in most crises		

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				105 498	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

Emergency preparedness and response is also supported by results expected to be achieved in other areas of work, as set out below.

Area of work	Expected result(s)

WHO'S CORE PRESENCE IN COUNTRIES

ISSUES AND CHALLENGES

The purpose of WHO's country presence is to mobilize the support of the entire Organization for achieving national health and development goals, and to enable a country to have a greater influence on global and regional public-health action. WHO's presence enables it to draw on the experience of a country in building a body of public-health knowledge that can benefit the rest of the world. Various studies have identified a set of concerns with regard to WHO technical cooperation at country level, including uneven progress in priority areas; poor coordination with the health work of organizations of the United Nations system and other international bodies; need for greater efforts to mobilize extrabudgetary resources; and unclear functions and status of WHO Representatives and Liaison Officers. In addition, WHO has not always been able to provide a focused and coordinated "one-WHO" response to country-specific needs.

WHO "country focus" aims at putting country health needs at the centre of WHO's work through the strengthening of WHO country offices, under the leadership of the WHO Representative or Liaison Officer. This requires a clear, country-specific, strategic agenda setting out both WHO's input into national-health and development-coordination mechanisms, and a country's contribution to international platforms and mechanisms. Although WHO's Country Cooperation Strategy is now well established, more needs to be done to ensure focus and selectivity on the basis of WHO's core functions, to achieve full support across the Organization, to adapt WHO's presence to the requirements of the strategic agenda, and to translate that agenda into a single WHO country plan, budget, resource allocation and operations.

Placing country health needs at the centre of WHO's work also requires maintaining and strengthening a country perspective in all aspects of its policy-related, representational, technical and managerial work. A shared understanding of the roles and responsibilities of different components of WHO and improved communication are critical for heightening the impact of WHO's work at country level. WHO Representatives and Liaison Officers need to be more empowered, accountable and significantly involved in the shaping of WHO's policies and strategies. Strong technical and operational country teams need to receive more effective backstopping from regional offices and headquarters according to specific country needs.

Lastly, the strategic focus towards strengthening WHO's work at country level has to have an impact on the way the entire Organization functions. This requires an adaptation of the way priorities are set, resources allocated and operations run by country, region and headquarters.

GOAL

To provide support to Member States for reaching their national health and development goals and to contribute to achievement of the health-related Millennium Development Goals by strengthening WHO's presence in countries.

WHO OBJECTIVES

To ensure relevance and effectiveness of the Organization's work and its accountability to Member States by adjusting WHO's presence to each country context, based on WHO's strengths; allocating technical and financial resources accordingly; and ensuring that country inputs guide WHO's policy, technical and advocacy work.

Indicator

- Number of countries in which the Organization has adapted its plan of work and reallocated its resources in order to address priority issues identified in the Country Cooperation Strategy by strengthening its country presence

STRATEGIC APPROACHES

Development, review and implementation of WHO Country Cooperation Strategies, ensuring that they are used as the basis and main input for WHO country plans and budgets; execution of WHO's core functions through adequate country core presence; strengthening of the managerial, technical and administrative capabilities of country teams; harnessing of the whole Organization's competence to a single country plan and budget, enabling country teams to perform; easing of communication and dialogue between levels and across technical areas of the Organization, and monitoring of the results of WHO's country focus at country level; promotion of strategic partnerships and coordination of external inputs to support national health development.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. WHO Country Cooperation Strategies that are clearly linked to national strategies and plans; set within such mechanisms as the Common Country Assessment and the United Nations Development Assistance Framework, building on, and contributing to, coordination among partner organizations; fully integrated within WHO's managerial process, thus guiding operational plans and allocation of resources.	• Number of countries with WHO presence or programmes that have an updated WHO Country Cooperation Strategy and a related single plan and budget, including regular budget and extrabudgetary resources	25% of countries with WHO presence	75% of countries with WHO presence
	• Effectiveness of mechanisms put in place to ensure that Country Cooperation Strategies are used as critical input for preparation of programme budget including all resources and work plans at all levels	Effective mechanisms in place between the three levels of WHO	Mechanisms in place are operating effectively
2. Adequate WHO country core presence and capability, with particular focus on the competency of WHO Representatives and Liaison Officers in carrying out WHO's advisory, brokering and catalytic functions at country level, and its direct support to operations.	• Level of adequacy of WHO country core presence and technical, managerial and administrative capability, including competency of WHO Representatives and Liaison Officers, and appropriateness of managerial systems, infrastructure and logistics at country level	Situation as per assessments of WHO's presence being carried out in 2004 and 2005, in countries where a cooperation strategy has been followed through and completed in accordance with established guidelines	Satisfactory execution of recommendations of assessments carried out in 2004, 2005 and 2006 in countries where a cooperation strategy has been completed
3. Systematic and permanent involvement of WHO country-office staff in formulation of global policy and strategy.	• Proportion of WHO Representatives and other WHO country-office staff providing inputs or involved in reference groups and other consultation mechanisms	Contribution of country-office staff to reference groups and other consultations in 2004-2005	All country offices invited to contribute to major Organization-wide consultations
4. Regular monitoring of the formulation and implementation of WHO's country focus policies and strategies, including an understanding of roles and responsibilities across WHO and the redistribution of resources toward regional and country offices, performed with involvement of all regional offices.	• Availability of WHO management information for the country focus policy, including a core set of data on resource allocation across WHO	Linked monitoring system in place in all regional offices and headquarters (end 2005)	Adequately functioning management information system and dissemination of results across the Organization
	• Effective network of country support units with participation of the three levels of the Organization	Effective country support units in place	Sustained, effective, functional country support units

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
5. Country offices accepted in practice by headquarters and regional offices as country-centred operations and receiving the technical support they require for exercising their core functions.	• Level of satisfaction among WHO Representatives and Liaison Officers with the technical support received from regional offices and headquarters for their country cooperation strategies	Results of the first qualitative survey on level of satisfaction of WHO Representatives and Liaison Officers (end 2005)	25% increase in level of satisfaction among WHO Representatives and Liaison Officers
	• Number of complaints raised within headquarters regarding unplanned activities or missions from headquarters and regional offices	Number of complaints received from WHO Representatives and Liaison Officers	No complaints received from WHO Representatives and Liaison Officers

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				197 829	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

WHO's core presence in countries enables the Organization effectively to deliver its technical support to Member States. As it supports virtually all the technical activities it is excluded from the tables showing linkages between areas of work.

KNOWLEDGE MANAGEMENT AND INFORMATION TECHNOLOGY

ISSUES AND CHALLENGES

WHO from its inception has been a knowledge organization, and in recent years has taken strides to reorient itself to make better use of that aggregate knowledge internally and externally to promote better health in Member States. Management of knowledge concerns use of the most effective ways to create, share and apply an organization's knowledge assets, and the culture, processes and tools needed to do so. It is an Organization-wide approach that will enable WHO to maintain its position as an authoritative source of information and knowledge for diverse audiences on issues related to public health. The approach provides a framework within which knowledge elements of various types and in appropriate media (information, individual and collective experience, expertise, data, publications, effective practices, and lessons learnt) are better captured, organized, shared and applied to practical problem-solving.

Information and communication technology provides the platform which interconnects the three levels of the Organization in a network within which learning can thrive and operations run efficiently. Beyond the challenges of setting up and maintaining the required physical infrastructure, there are others related to the changes in organizational culture that will be needed in order for collaboration and knowledge sharing to take place effectively. The Organization also plays a crucial role in promoting and facilitating the application of effective knowledge management and information and communication technology for improving health within Member States. In this regard, it faces challenges in contributing to build up relevant capability in countries, fostering and monitoring progress in ability to use electronic information in support of health care, strengthening exchange of information, and promoting the effective use of information and communication technology in health care.

The linking of knowledge management and dissemination with information technology and communication reflects a holistic approach and puts into practice the values of cooperation and applied problem-solving that WHO promotes. The value of the experiential knowledge of individuals is recognized, as well as that of formally generated knowledge, and maximum effect is drawn from both. All parts of the Organization contribute to, and benefit from, its knowledge pool. To that end a comprehensive Organization-wide strategy is being implemented aimed at putting knowledge assets to best use for all. Challenges include ways to address inequities in information systems in countries, to create a uniform knowledge environment with common information-exchange standards, to enable and empower communities of practice to create, share and apply knowledge more efficiently and effectively, and to improve the Organization's own system for delivery of the information needed for the effective and efficient management and administration of its programmes, including in the country offices. In this regard, a global management system is being set up that meets the Organization's requirements and can be scaled to the size of each WHO office while providing it with the information needed to perform its role.

As the Organization becomes dependent on information and communication technology in the conduct of its work, it will, with its diverse and decentralized environment, become increasingly reliant on an information architecture that overcomes physical and organizational boundaries in order to share and promote knowledge and experience. In this context, issues of security (protection) and assurance (reliability and stability) of networks and related infrastructure are important.

GOAL

To foster, equip and support an environment that encourages the generation, sharing, effective application and dissemination of knowledge in Member States and within the Organization in order to promote health, using appropriate knowledge management and information and communication technology.

WHO OBJECTIVES

To promote an organizational culture supported by an information technology infrastructure that responds to needs of users in Member States and within the Organization related to knowledge management and information technology.

Indicators

- Adequacy of needs-based knowledge management programmes in health systems in Member States and throughout the Organization
- Availability of an appropriate and cost-effective information and communication technology infrastructure that meets the needs of users throughout WHO
- Effective implementation of the Organization-wide global management system

STRATEGIC APPROACHES

Promotion of Organization-wide participation in a governance mechanism to guide and monitor strategic information and communication technology plans, with phased development and delivery systems; of the use of cost-effective mechanisms for communication technology across the Organization which will permit efficient functioning by administrative and technical departments and respond to the needs of a diverse user base; of formulation of policies and strategies to ensure that information and knowledge captured, generated and shared is validated and of high quality; incorporation of needs assessment in knowledge management and information technology projects throughout WHO; implementation of global platforms for information and communication technology and data, with reliable and adequate access from all offices; identification and promotion of effective practices in knowledge management and information technology; ensuring that WHO's health information products and services are relevant to the needs of countries, timely and accessible; increase the number and quality of knowledge workers; promotion of, and support to, communities of practice in health systems and throughout WHO; provision of effective support to ensure efficient infrastructure and collaborative environment, including communications systems, applications, user training and computer security; use of an Organization-wide governance to guide the development and implementation of effective and coordinated strategic information technology and knowledge management plans; development of a culture of "experience" along with "expertise"; development of, and support for, information and communication applications for health systems that are integrated with learning networks and systems; development of shared standards and compatible systems for information and document management to help foster knowledge exchange, retention, and creation; establishment of mechanisms to capture experiential knowledge; promotion of innovation in collaborative workspaces in order to further integrate learning systems, work processes and information technology; provision of support for national capacity building and raising public awareness.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Knowledge management policies and strategies developed to enable learning in health systems and in the Organization.	• Availability of effective policies, practices, toolkits and training for knowledge management in Member States and the Organization	Policies, toolkits and training for knowledge management available in some offices	Access to effective policies, practices and toolkits by target health systems and the entire Organization; most target countries engaged in their development
	• Existence of communities of practice to foster managerial and programmatic effectiveness	Some communities of practice supported within the Organization	Thriving communities of practice in target health systems and throughout the Organization
2. WHO's information products and health information and communication technology seamlessly integrated into learning systems.	• Extent of use of custom-organized interfaces for sharing information	Suboptimal use of interfaces for sharing information	Better use of knowledge-sharing environments
	• Proportion of staff who contribute to and benefit from the collective knowledge pool	Vertical knowledge sharing within the Organization	Knowledge sharing across institutional boundaries

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
3. Unified information management and technology architecture at WHO designed and implemented.	• Percentage of key documents used by the Organization for decision-making that are captured, organized and stored electronically	Most current (but not less recent) documents captured and accessible electronically	All key documents captured, organized and stored electronically
	• Degree of commonality of standards for information and communication infrastructure, across all WHO locations	Base standard of compatible technology components available, founded on informal agreements	An agreed set of standards and products to meet business requirements for information compatibility, enable sharing of expertise, and achieve economies of scale
4. Appropriate technology infrastructure and information strategies in place to meet the business requirements of functionality, reliability and cost-effectiveness.	• Reliability of access to information technology systems and information content	Most WHO locations linked through a single supplier	Demonstrated competitiveness of communications networks, compared to industry standards and agreed business requirements
	• Adequacy of information technology systems and information content at country level	Variable levels of information technology infrastructure and service at country level	Strengthened country office infrastructure to meet a common service level
5. WHO's information products and tools to use electronic information applied effectively and efficiently to address health issues in countries.	• Accessibility of frameworks and tools to make it possible to apply relevant information, including electronic, in support of health care in countries	Limited availability of frameworks and tools in countries for applying information	Frameworks and tools accessible and available for all priority WHO work in countries
	• Cost-effectiveness of the use at country level in support of health care of available information products and tools for use of electronic information	Suboptimal adoption and use of available information products	Greater adoption and more consistent use of available information products through training, outreach and cross learning
6. Selected priority information products in relevant languages from headquarters and regional offices appropriately generated, disseminated and archived.	• Availability of information in relevant languages and in collaboration with regional offices	Most information products available in selected official languages	Priority information products available in most commonly spoken languages in countries
	• Number and distribution of visits to, and downloads from, WHO's web site	Over 2.5 million visits and 2 million downloads per month	Over 4 million visits and 3 million downloads per month
	• Impact of WHO information products, as measured by citations in scientific literature, reviews, or mentions in the media	Impact consistent with broad coverage by global media and international research literature	Impact indicates more directed use in Member States through priority institutional initiatives

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
7. Cost-effective provision of existing technologies to the Organization.	• Availability of corporate applications, supporting both health technical functions and administrative support functions, according to established business-service requirements	Continuity strategies limited Varying levels of systems availability and support, inconsistent with the business need	Compliance with agreed information technology service levels (including service continuity plans) funded and implemented to meet current business requirements in terms of security, accuracy and usability
8. Core programmes sustained with appropriate streamlined business processes and control mechanisms; fully operational global management information system in place that facilitates the Organization's performance and can be scaled to the size of each WHO office.	• Availability of global information for managerial and administrative purposes • Level of required reconciliation of administrative data	Information available locally in fragmented form Fragmented information systems that require manual reconciliation	Comprehensive, timely information available electronically Reconciliation eliminated

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				139 043	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

Knowledge management and information technology enables the Organization effectively to deliver its technical support to Member States. As it supports virtually all the technical activities it is excluded from the tables showing linkages between areas of work.

PLANNING, RESOURCE COORDINATION AND OVERSIGHT

ISSUES AND CHALLENGES

WHO introduced results-based management for Programme budget 2000-2001. Since then, its application has been refined and extended across all levels of the Organization with each subsequent programme-budget cycle. These positive steps have led to a stronger emphasis on results, better targeting of resources, and greater accountability in support of the Organization's country focus. Nevertheless, various issues remain to be resolved if results-based management practices are to be applied consistently across all institutional levels and areas of work.

Difficulties experienced include ensuring consistency between strategic and operational planning, making adequate use of lessons learnt from performance assessments and properly reconciling the unique needs of countries and country workplans with the achievement of Organization-wide objectives and expected results. The timeframes for various managerial processes have been reviewed in the light of the need for mechanisms for closer consultation and coordination between headquarters, and regional and country offices.

The degree of acceptance and compliance with Organization-wide rules has varied considerably within headquarters, across regions, and in countries, hindering the integrated planning, monitoring and reporting necessary for more effective programme management. Offices have not internalized the culture of planning, performance monitoring, and reporting that is essential for implementing results-based management.

For the biennium 2006-2007, the main challenge will be to revise WHO's managerial framework in the light of recommendations arising from a review undertaken in 2004-2005 of its scope, periodicity and interlinkage of components, namely, strategic and operational planning reflecting country focus, an integrated programme budget covering all sources of funds, performance monitoring, quality assurance, evaluation and reporting. The revised framework will then be integrated into the day-to-day operations of programmes at all levels. There is also a need to improve intra-Organizational cooperation and to use shared processes and a management information system compatible throughout the Organization. An effective system for planning, mobilization, coordination and administration of voluntary resources will be extended to all levels of the Organization in order to realize a single programme budget that integrates all sources of funds and to meet the Director-General's commitment to moving resources from headquarters to regions or countries, with a target of 75% of resources to regions and countries and 25% to headquarters.

Organizational culture must continue to evolve so that programme managers and decision-makers at all levels effectively use the information generated by the managerial system to improve their performance. In order to facilitate this process, changes need to be made to harmonize administrative practices and procedures within a context of decentralization; and an integrated learning and support framework for results-based management needs to be introduced.

GOAL

To apply consistently across the Organization the principles of results-based management and related processes, namely, strategic and operational planning, resource planning and coordination, performance monitoring, quality assurance and evaluation, in support of WHO's leadership role in international health and its programme development and operations.

WHO OBJECTIVES

To implement fully functional Organization-wide systems and mechanisms for results-based management that provide effective support for WHO's accountability policy and country focus.

Indicators

- Proportion of expected results that are fully achieved at each organizational level
- Number of ad hoc programme evaluations requested by stakeholders, as an expression of confidence in the Organization's quality assurance and evaluation framework

STRATEGIC APPROACHES Development of understanding of results-based management principles and compliance with WHO's managerial framework; strengthening of institutional and staff capacity for long-term strategic planning, biennial programming and budgeting, operational planning, performance monitoring, quality assurance, evaluation and reporting; strengthening of the Organization's programme management information system, including systems for resource planning and coordination; establishment of a regular system for the training and coaching of staff in the principles of results-based management.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. WHO's revised managerial framework and its related processes applied in a coordinated and consistent manner for strategic planning, biennial programming and budgeting, operational planning, performance monitoring and reporting, including support for the country focus.	• At each organizational level, proportion of areas of work for which workplans have been developed and monitored and which are fully consistent with strategic plans and the programme budget	50%	75%
2. Global system for planning, mobilization, coordination and administration of voluntary resources in support of results-based management and the country focus applied throughout the Organization.	• Proportion of headquarters programmes, and regional and country offices in which the Organization-wide system for planning, mobilization, coordination and administration of voluntary resources is consistently applied	None	100%
3. Capacity for quality assurance services strengthened and advice and assistance provided to make programme delivery across all levels of the Organization more relevant and cost effective.	• Proportion of programme managers' requests for assistance in making programme delivery more relevant and cost effective fulfilled	None	75%
4. Culture and practice of results-based management sustained at all levels of the Organization.	• Proportion of professional staff, at each level of the Organization, trained in the principles and practices underlying the revised WHO results-based managerial framework (strategic and operational planning, performance monitoring, quality assurance, evaluation and reporting)	10%	75%
5. A globally compatible programme management information system fully in operation, that integrates data from all levels of the Organization, and supports efforts to improve performance and accountability at all levels, and to focus on country work.	• Proportion of agreed core data set that is provided in workplans at each level of the Organization and captured in the global database	None	75%

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
6. WHO's work systematically evaluated to assess its medium-term impact and ensure good stewardship of the Organization's resources.	• Number of thematic and programmatic evaluations completed during the biennium in accordance with the framework on programmatic evaluation	None	8
7. Risks to the Organization identified and mitigated by controls designed to ensure good corporate governance.	• Level of implementation of annual audit plans	Fulfilment of annual audit plan	Fulfilment of annual audit plan

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				27 578	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

Planning, resource coordination and oversight enables the Organization effectively to deliver its technical support to Member States. As it supports virtually all the technical activities it is excluded from the tables showing linkages between areas of work.

HUMAN RESOURCES MANAGEMENT IN WHO

ISSUES AND CHALLENGES

As the world's leading public health agency, WHO needs a versatile, productive, skilled and motivated workforce, dedicated to the Organization's mission. The challenge to WHO is therefore to attract and retain the most talented women and men, from all Member States.

Good planning of human resources, based on actual and projected needs, is essential to the effective management of staff. Managers need to have employment packages that are closely aligned to the type and duration of the function performed. Changes made in previous years will be evaluated to ensure that WHO has an appropriate range of contract choices at its disposal.

WHO needs to promote continuously an organizational culture in which staff achieve high levels of performance through sound management and development; and in which they enjoy fair treatment, job security and safety, a healthy working environment, and staff/management relations based on mutual trust and respect.

Following the full implementation of WHO's global competency framework during the biennium 2004-2005, the main challenge will be to ensure that human resources management fully assimilates the competencies and behaviours of the new management culture. WHO's new global management and leadership development programme is a key part of this process. The impact of increased investment in staff development and learning through creation of the global staff development fund, and the learning programmes it will support, should produce a measurable cultural shift across the Organization, leading to higher levels of satisfaction and better performance.

In view of the global nature of its public health operations, the Organization needs staff members who have professional experience across regions and countries. This major challenge will be met by the introduction and implementation of a regulated system of mobility that will apply to all internationally recruited staff. The mobility programme will build on the experience of the voluntary scheme introduced in the 2004-2005 biennium, applying the lessons learnt. The new system will need to balance the interests of programmes and staff with those of the Organization.

WHO will continue to participate actively in pay and benefits reforms, within the United Nations common system, with a view to making the compensation package more responsive to, and supportive of, the current needs of Member States, United Nations organizations and staff. The proposed reforms include introduction of performance-related pay, grouping of grade levels, and the establishment of a senior executive service.

The recruitment strategy designed to broaden the diversity of the WHO workforce will be reviewed and amended as necessary.

GOAL

To apply best practice in all aspects of human resources management at all organizational levels, in support of WHO's leadership role in international health.

WHO OBJECTIVES

To provide the strategic direction, policies and procedures necessary to ensure that human resources services are delivered in a timely and effective manner in support of WHO's role to promote and protect health.

Indicator

- Operational excellence in the timely delivery of high-quality human resources services at headquarters and in regional and country offices

STRATEGIC APPROACHES

Formulation of policy, design of systems and delivery of human resources services to meet current and future organizational goals through continuous improvement of technical and people-management capabilities, processes and systems.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. New global human resources information system and streamlined, re-engineered procedures established, providing staff globally with improved quality and quantity of information and better access.	• Availability of internally consistent global information across offices	Lack of internally consistent human-resources information throughout the Organization	Human resources module of the global management system implemented and operational
	• Degree to which organizational units can be reprofiled and analysis of gap between required and available skills and competencies can be undertaken	Reprofiling limited due to lack of tools and information	All organizational units using reprofiling tools and skills-gap analysis
2. Effective learning programmes that meet staff and organizational needs launched, ensuring the effective use of individual development plans across the Organization.	• Level of staff satisfaction with development opportunities offered at WHO	Limited number of development opportunities	Expanded availability of learning programmes based on assessed demand
	• Level of satisfaction with management and leadership capacity at WHO reported by staff	Limited leadership and management learning programme available	Leadership and management learning programme implemented for all senior and middle managers
3. Rotation and mobility system fully implemented, based on a compendium of vacancies issued at least once a year.	• Proportion of staff having completed their maximum standard assignment length who participate in the rotation and mobility programme	Limited voluntary rotation and mobility	80%
4. Conditions of service improved and staff-friendly policies implemented; WHO pay and benefits system brought into line with the United Nations field-oriented organizations' system.	• Degree of improvement in staff-friendly policies	Special-operations living-allowance policy not applied. Lack of a post-traumatic stress disorder programme and global counselling services	Implementation of special-operations living-allowance policy; post-traumatic stress disorder and stress management programmes in place
5. Procedures and systems maintained, enabling the Organization to recruit staff and meet its contractual obligations as an employer, while providing a caring and supportive environment for all staff.	• Timeliness of payment of salaries and allowances to all staff	Delays in payment of entitlements	Automatic processing of entitlements and lump sums
	• Frequency of appeals for non-compliance with the Organization's regulatory instruments	Completed survey on organizational climate	Improved yearly survey results

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				52 261	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

Human resources management in WHO enables the Organization effectively to deliver its technical support to Member States. As it supports virtually all the technical activities it is excluded from the tables showing linkages between areas of work.

BUDGET AND FINANCIAL MANAGEMENT

ISSUES AND CHALLENGES

Budget and financial management are continuing functions that must be efficient and allow for sound internal control to support the work of the Organization at all levels. Flexibility is required in order to accommodate circumstances and needs particular to individual locations; consistency is also necessary to ensure that the correct balance is struck between service and control. Timely, accurate and relevant management information is vital to support the delivery of work across the Organization, while integrated reporting is necessary to improve the planning and monitoring processes of the Organization – meeting the needs of managers as well as the statutory and other requirements of Member States. The growth of voluntary contributions and the increasing complexity of donor agreements place increasing demands upon the Organization. There is therefore a need for appropriate strategies to ensure that the integrated programme budget is financed on a sound, sustainable basis. Staff involved in budget financial management should have the necessary skills, expertise and capability to handle the increased volume and complexity of financial resources, associated reporting and other requirements that will result.

A major challenge is to continue to improve budget and financial management through increased decentralization, including the development of appropriate policies, procedures and guidance. There is a need for new information technology systems that are simplified and streamlined and that respond efficiently to both changing programme requirements and the concerns of Member States. An internal control framework should also be maintained to promote accountability and minimize the risk of fraud.

Appropriate use of financial information to support the health activities of the Organization is crucial to ensuring effective management by the technical areas in an accurate and timely manner. Financial information is one of the measures by which success in achieving objectives can be judged by Member States and others that provide financial resources or benefit from the output of the Organization. Relevant and effective support and guidance are necessary to implement policies.

GOAL

To apply best practice in all aspects of budget and financial management at all organizational levels within a sound internal control framework, in support of WHO's leadership role in international health.

WHO OBJECTIVES

To follow best practice in budget and financial management coupled with integrity and transparency, providing effective and efficient support for budget and financial administration across the Organization for all sources of funds, including relevant financial reporting at all levels, both internally and externally.

Indicators

- Timely financial information and accessible analytical tools that allow managers at all levels of the Organization to make well-informed decisions on planning and operational matters
- Budget presentation, implementation and monitoring, enabling Member States and other donors to judge financial performance
- Acceptance by governing bodies of the biennial financial report, audited financial statements (including an unqualified audit opinion) and the interim financial report and statements
- Response to internal and external audit report recommendations, leading to enhanced accountability and supporting appropriate internal control

STRATEGIC APPROACHES

Formulation of relevant policies within a framework of financial integrity and continuous improvement in order to assure a seamless budgetary and financial process, efficient, effective operations, and a sound accountability framework, for all sources of funds and at all levels of the Organization; provision of a balanced response to the different, but equally important, requirements of Member States and donors as providers of funds, and of the Organization, at all levels.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Policies and guidance prepared for implementation of new, streamlined functions under delegated authority to countries and regions in line with implementation of the new global management system.	• Comprehension and implementation throughout the Organization of policies underpinning the global management system	Updated WHO Manual and related procedures and appropriate training programme	Revised policy and procedures fully reflected in the WHO Manual and training programme carried out at all levels
2. Integrated budget estimates drawn up, including financing strategies; income and expenditure projections, monitoring and reporting carried out for all sources of funds on a fully integrated basis.	• Timely and relevant submission of budget estimates to governing bodies • Timely reporting to satisfy both needs of internal management and requirements of Member States	Compliance with Financial Regulations Global consolidated database updated by 18th working day each month; ad hoc reports on financial implementation	Compliance with Financial Regulations Global consolidated database updated by 10th working day each month; monthly reporting by 15th working day
3. Statutory and other financial reports prepared and submitted to the Health Assembly in accordance with WHO Financial Regulations and Financial Rules, policies and procedures.	• Submission of interim financial report for biennium 2006-2007 to External Auditors by 31 March 2007 • Submission of final financial report for biennium 2006-2007 to External Auditors by 31 March 2008 • External audit opinion and recommendations	Interim financial report finalized by 31 March 2007 Final financial report finalized by 31 March 2008 Unqualified audit opinion	Interim financial report finalized by 28 February 2007 Final financial report finalized by 28 February 2008 Unqualified audit opinion
4. Financing strategy for integrated budget management (income and accounts receivable) drawn up and effectively implemented.	• Timely recording of income • Accuracy of income database • Level and timeliness of collection of receivables for all sources of funds	Income recorded within 5 days Chart of accounts aligned with programme budget Actual rate of collection 2004-2005	Income recorded within 2 days Chart of accounts aligned with programme budget Improved rate of collection compared with 2004-2005
5. Expenditure and accounts payable managed in order to implement the integrated programme budget.	• Accuracy of expenditure database • Timely payment of suppliers and contractors according to contract terms	Chart of accounts aligned with programme budget Payment within 10 days of receipt of payment instruction	Chart of accounts aligned with programme budget Payment on due date of contract
6. Funds of the Organization invested and foreign exchange risks managed within acceptable liquidity and risk parameters in order to maintain the necessary level of liquidity and maximize investment potential.	• Level of investment earnings as compared to accepted benchmarks • Efficiency of banking and payment operations • Execution of hedging operations within budget appropriated by the Health Assembly	Actual performance 2002-2003 compared to benchmark investment percentage Level of bank charges for 2004-2005 Rate of protection achieved for 2004-2005 within budget appropriation	Out performance of benchmark investment percentage by 0.25% No increase in level of bank charges Full exchange-rate protection achieved within budget appropriation

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				45 661	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

Budget and financial management enables the Organization effectively to deliver its technical support to Member States. As it supports virtually all the technical activities it is excluded from the tables showing linkages between areas of work.

INFRASTRUCTURE AND LOGISTICS

ISSUES AND CHALLENGES

The ability of WHO to deliver its health programmes throughout the world depends on the support and services it provides in infrastructure, which includes making safe and adequate office space available to its employees. United Nations facilities are potential targets for terrorist attack; constant attention is therefore needed to ensure the safety and security of all WHO staff. The Organization's various geographical locations affect the quality and choice of available infrastructure services, posing challenges for the provision of a safe, equitable and affordable service to all WHO staff. The broad challenge is to make sure that administrative support and security are appropriate yet economical; no resources should be directed unnecessarily from other essential programme activities.

Infrastructure services cover a range of infrastructure and logistic support functions essential for all WHO sites: accommodation, office supplies and all matters related to office services and concessions; general building management and maintenance, including provision of utilities; servicing of conferences and meetings; production, printing and distribution of publications and technical, administrative and conference documents; archives, mail and security; information on travel and travel policy; and contracting and procurement.

In addition to the procurement of drugs and medical supplies, other goods and services have to be purchased and delivered worldwide. A significant portion of this work is related to emergency and humanitarian aid, in situations where commercial alternatives are unavailable or unaffordable. Not only must contracting and procurement services be efficient and cost effective, they must also be unusually flexible in order to cope with unpredictable demands. The challenge is to purchase these commodities and services in the most cost-effective manner, through umbrella agreements and electronic commerce facilities, and to ensure their timely delivery to the recipients concerned.

GOAL

To apply best practice in all aspects of infrastructure support at all organizational levels, in support of WHO's leadership role in international health.

WHO OBJECTIVES

To frame an enabling policy and creating an institutional environment to support the timely implementation of WHO's programmes in Member States.

Indicator

- Appropriateness, timeliness, cost-effectiveness and reliability of infrastructure and logistic support services at all organizational levels

STRATEGIC APPROACHES

Sharing of best practices and resources across the Organization and implementation of innovative cost-reduction mechanisms; drafting of service-level agreements that improve management of client expectations; fostering of collaboration with other organizations of the United Nations system whenever cost-sharing is viable.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Established offices operated in a cost-effective and efficient manner.	• Number of established best practices adopted in order to effect efficiency gains	No best practices adopted for implementation	Minimum of 8 best practices adopted
2. Global governing bodies and technical meetings provided with effective infrastructure and logistic support.	• Number of services that need to be refined	Number of services revised and adapted in previous year	Decrease in number of issues addressed and zero recurrence

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
3. Health supplies of the highest quality at the best price procured for Member States and technical programmes.	• Increase in the proportion of direct procurement carried out using negotiated agreements (such as UN Web Buy)	Percentage of direct procurement as at end of 2005	10% increase in direct procurement
4. Security and safety of grounds and premises improved.	• Number of WHO sites that comply with minimum operating security standards	Complying sites as at end of 2005	All sites
5. Real estate facilities improved.	• Availability of an updated 10-year rolling master plan of real estate projects	Master plan of previous biennium	10-year rolling master plan adopted
	• Proportion of projects implemented with financing from the Real Estate Fund that deviate from recognized best practice for local construction and environmental norms	Percentage of implemented projects that deviate from best practice at end of 2005	Less than 10% of implemented projects that deviate from best practice

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				134 617	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

Infrastructure and logistics enables the Organization effectively to deliver its technical support to Member States. As it supports virtually all the technical activities it is excluded from the tables showing linkages between areas of work.

GOVERNING BODIES

ISSUES AND CHALLENGES

The formal contribution of Member States of WHO to its work takes place within a series of governing bodies at global and regional levels. The work of WHO also contributes to, and is influenced by the United Nations system as a whole, and the linkage of WHO governing bodies to those of relevant parts of the system is important.

As the framing of appropriate public-health policy becomes more complex and crucial, WHO's governing bodies and those of relevant bodies of the United Nations system must be provided in the most efficient and effective way with both the input and the setting required for informed decision-making at global and regional levels. Careful and deliberate selection of the most pertinent issues, and greater participation and transparency, are essential in order to sharpen the focus of debate during shorter governing body sessions with less documentation. In drawing up agendas and prioritizing topics for consideration, dialogue between Member States and between regional- and global-level governing bodies must be maintained in order to bring about consensus on technical and policy matters.

As the number of governing body sessions has grown, the level of attendance has increased, and requirements for documentation and information have been more complex, so has the burden of the demanding, skilled and highly pressured work that needs to be performed by the language, documentation, document production, and meeting services. Moreover, in view of the importance of plurality of languages for assuring access of all Member States to accurate and concise scientific and technical information and for improving health policies in the world, a considerable volume of material has to be edited, translated and made available in all official languages of the Organization. New technologies facilitate the dissemination of documentation, making it possible, for example, rapidly to issue documentation for governing body sessions on the Internet; yet distribution of printed material is still needed in order to assure availability of documentation everywhere.

The issue of multilingualism throughout WHO needs to be viewed in the context of the Organization's communications with Member States and the world.

The rise in the number of governing body subsidiary sessions and increased need for language services has meant that costs in this area of work have grown considerably. The high cost of individual sessions, especially at regional level, has meant that only a few countries could consider hosting meetings.

GOAL

To ensure sound policy on international public health and development that responds to the needs of Member States.

WHO OBJECTIVES

To assure the good governance of WHO through efficient preparation and conduct of the regional and global governing body sessions, and effective policy-making processes.

Indicator

- Greater consensus in deliberations of the Health Assembly, Executive Board and regional committees

STRATEGIC APPROACHES

Expansion and improvement of communication and coordination channels between Member States, regional and global governing bodies, and WHO's Secretariat; more effective use of technology and better control throughout preparation process in order to speed up provision of concise and accurate documentation; careful review of the agendas of governing body meetings to ensure their relevance to WHO policy development; development of methods to encourage participation of Member States, organizations of the United Nations system and other intergovernmental bodies in the work of governing bodies.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Resolutions adopted that focus on policy and strategy and provide clear orientations to Member States and WHO's Secretariat on their implementation.	• Proportion of resolutions adopted that focus on policy and can be implemented at global, regional and national levels • Appropriateness of health contents in resolutions or policies of other bodies in the United Nations system		
2. Communication between Member States, Executive Board members and WHO's Secretariat improved.	• Frequency of effective use of communication channels between Member States and governing bodies at global, regional and country levels, concerning the work of WHO		
3. Governing body meetings held in all the official languages of WHO at global level and in agreed official languages for the regional committees.	• Proportion of governing body meetings held in appropriate official languages • Timeliness and availability of documentation in the official languages • Adequacy of multilingualism in WHO		
4. Communication and coordination in establishing the work programmes of regional and global governing bodies improved.	• Degree of congruence of agendas and resolutions of the regional and global governing bodies		

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				37 403	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

Governing bodies enables the Organization effectively to deliver its technical support to Member States. As it supports virtually all the technical activities it is excluded from the tables showing linkages between areas of work.

EXTERNAL RELATIONS

ISSUES AND CHALLENGES

In promoting integration of a health dimension into social, economic and environmental development, WHO seeks to achieve greater impact through its Member States; and by joining forces with other bodies of the United Nations system and a range of institutions offering knowledge and experience in other fields. WHO's corporate approach to cooperation with current and future partners is implemented through its external relations.

To that end, WHO maintains operational linkages with intergovernmental, governmental and nongovernmental partners, regional political bodies, and parliamentary groups. Cooperation with development banks and with institutions of the European Union has developed and needs to be further strengthened. WHO leads major initiatives to coordinate health-related activities in the United Nations system, and has striven to assure the prominence of health on the agenda of the international community.

Member States provide the Organization's core and extrabudgetary resources. The corporate approach to sustainable financing of WHO activities resulted in better alignment of voluntary contributions with WHO's programme budget. Several governments moved to multiyear commitments, thereby assuring predictability and coherence. A formal consultative exercise for interested parties covers the work of WHO as a whole. In the rapidly changing environment for development cooperation, this donor base will be expanded in order to meet the requirements of WHO activities. Targeted approaches to foundations, including in the context of global alliances, also produce a significant increase in support.

Recognition is growing of the benefits of greater collaboration with the private sector in order to improve public health outcomes. WHO is increasingly engaged in public-private partnerships and global alliances which involve a variety of stakeholders.

WHO's work on public-private interactions for health will emphasize cooperation with companies to improve access to health-related commodities; promote research and development; redress company practices that have a negative impact on public health; and provide support to Member States on interaction with the private sector. Guidelines have been drawn up to provide a framework to technical programmes. The Committee on Private Sector Collaboration reviews all proposals in order to advise the Director-General.

Nongovernmental organizations play a growing role in shaping and implementing both global and national health policies. Their contribution is reflected in the various kinds of interaction they have with WHO. In addition to maintaining a system for formal relations with such organizations, WHO needs to make collaborative arrangements more coherent and efficient, improve dialogue with civil society, and work more efficiently with and through organizations in advocacy and outreach efforts at country level.

The growth in interactions with partners throughout the Organization raises the question of both strategic management for a corporate approach, and increasing risk of conflicts of interest. Existing rules and methods for the establishment of partnerships need to be developed further, especially in terms of governance, respect of WHO's mandate, and promotion of public health.

Relations with the media and the provision of information to the general public are important for raising awareness of health issues and creating a positive image of WHO. Ensuring that WHO "speaks with one voice" will reinforce the impact of a common message, based on evidence, and enhance WHO's image.

In collaboration with nongovernmental organizations and the private sector, and through WHO's regional offices, efforts are being made to improve support for community public health using the Health Academy project, advocacy, and documentation of external partners' activities at country level.

GOAL

To ensure that health goals are incorporated in overall development policies, and that resources for health are increased.

WHO OBJECTIVES

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

- Number of functioning partnerships established with bodies of the United Nations system, the private sector and civil society

STRATEGIC APPROACHES

Respect of the programme adopted by the Health Assembly; introduction of measures to manage conflict of interest with the private sector; facilitation of exchange of information between major target groups in health information marketplace; greater promotion of the health agenda in political and socioeconomic spheres; better staff awareness of issues related to collaboration with the private sector, including conflict of interest.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. 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.	• Number of consultation and briefing sessions with WHO's sister agencies, other organizations and interested parties in the health sector • Number of policy areas where there is congruence with other stakeholders		
2. Effective mechanism for coordination of input to and feedback from important international forums, including major United Nations conferences and summits, and the Millennium Development Goals.	• Degree of reflection of WHO's health goals and priorities in final declarations and plans of actions of global, regional and national conferences, and development agendas		
3. New partners mobilized for WHO, notably through global alliances and improved interaction with the private sector.	• Number of private-sector partners working with WHO to achieve public health outcomes • Number of assessments made for the Committee on Private Sector Collaboration, and level of support to regions and clusters		
4. Improved knowledge of nongovernmental and civil society organizations working with WHO, and increased transparency, through enhanced communication and policy dialogue.	• Number of targeted organizations that benefited from training sessions and seminars using WHO policy papers, tools, and guidelines on interaction with civil society organizations		
5. Health Academy project extended to pilot Member States in all regions.	• Proportion of Member States in which the Health Academy has been established		

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				35 600	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

External relations enables the Organization effectively to deliver its technical support to Member States. As it supports virtually all the technical activities it is excluded from the tables showing linkages between areas of work.

DIRECTION

ISSUES AND CHALLENGES

The overarching theme for the Organization will continue to be "results in country". This presents a challenge to senior management to implement activities in such a way that they reflect the priorities and concerns of Member States, and draw on the synergistic strengths of headquarters, and the regional and country offices.

The Organization must continue to increase the proportion of resources allocated at country level, while maintaining stewardship of its technical agenda. In doing so, an appropriate balance needs to be struck between the provision of global public goods and support to country-level action.

As a whole, WHO will aggressively pursue measurable health outcomes, particularly as related to the Millennium Development Goals. Following the shift to results-based planning and budgeting, the Organization will engage more thoroughly in results-based auditing to assure the greatest level of efficiency and accountability.

As the number and types of organizations involved in global public health continues to increase, WHO must provide the political and technical leadership necessary to maintain the provision of health services, development and refinement of health infrastructure, and the implementation of public health policy.

Lastly, WHO must create an organizational culture that produces sound results by means of strategic thinking, prompt and effective action, teamwork, flexibility, networking, and innovation.

GOAL

To advance global public health and contribute to attainment of the Millennium Development Goals, particularly directing efforts at country level.

WHO OBJECTIVES

To direct the work of the Organization within the overall framework of WHO's Constitution, so as to maximize Organization-wide contribution to the work of Member States in achieving significant gains in health status.

Indicator

- Extent of delivery of all areas of work set out in the Programme budget, as reflected in the end-of-biennium performance assessments, and programmatic and thematic evaluations

STRATEGIC APPROACHES

Close and permanent interaction with Member States and partners; collaborative institutional development and coordination of actions between headquarters and regional and country offices; due diligence in stewardship, governance and oversight of resources; all these approaches carried out in accordance with WHO's Constitution and to the effect of realizing results at country level.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Effective direction and management of the Organization.	• Level of endorsement of reports submitted to the governing bodies	Endorsement of all regular reports on implementation of resolutions and decisions	Endorsement of all regular reports on implementation of resolutions and decisions
2. Coherence and synergy between the work of the different parts of the Organization.	• Degree of collaboration and coordination for Organization-wide programme planning and implementation; and communication of policies and strategies during meetings of senior management across the Organization	All global planning coordinated between senior managers of headquarters and regional and country offices	All global planning coordinated between senior managers of headquarters and regional and country offices

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
3. Legal status and interests of the Organization protected through timely and accurate legal advice and services.	• Responsiveness to requests for legal advice and services	All legal inquiries addressed and documented	All legal inquiries addressed and documented
4. Awareness of Member States and global partners of the work and role of WHO, and its contribution to significant developments in public health infrastructure, services, policy and outcomes.	• Accuracy of representation of WHO's work in major international, regional and country media	All WHO priority programmes accurately reported to relevant media	All WHO priority programmes accurately reported to relevant media
5. Catalytic and start-up funds provided for programmes of particular need under the purview of the Director-General and Regional Directors.	• Strategic allocation of the Director-General's and Regional Directors' development funds toward activities and initiatives that advance the mission of the Organization	Funds allocated as directed by the Director-General and Regional Directors	Funds allocated as directed by the Director-General and Regional Directors

RESOURCES (US$ thousand)

		Assessed contribution[a]	Voluntary contribution	All financing	Percentage by level
TOTAL 2004-2005					
TOTAL 2006-2007				28 590	
level at which allocated	country				
	regional				
	headquarters				
	percentage by source of financing				

[a] Includes Miscellaneous Income.

Direction enables the Organization effectively to deliver its technical support to Member States. As it supports virtually all the technical activities it is excluded from the tables showing linkages between areas of work.

III. STATISTICAL ANNEXES

DETAILED ALLOCATION BY AREA OF WORK AND OFFICE (ASSESSED CONTRIBUTION[a] AND

Area of work	Africa								
	Country			Regional			Total		
	Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing
Communicable disease prevention and control									
Communicable disease research									
Epidemic alert and response									
Malaria									
Tuberculosis									
HIV/AIDS									
Surveillance, prevention and management of chronic, noncommunicable diseases									
Health promotion									
Mental health and substance abuse									
Tobacco									
Nutrition									
Health and environment									
Food safety									
Violence, injuries and disabilities									
Reproductive health									
Making pregnancy safer									
Gender equality, women and health									
Child and adolescent health									
Immunization and vaccine development									
Essential medicines									
Essential health technologies									
Policy-making for health in development									

[a] Includes Miscellaneous Income.

ESTIMATE FOR TOTAL VOLUNTARY CONTRIBUTION), BY REGION, 2006-2007 (US$ THOUSAND)

Area of work	Africa								
	Country			Regional			Total		
	Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing
Health system policies and service delivery Human resources for health Health financing and social protection Health information, evidence and research policy Emergency preparedness and response WHO's core presence in countries Knowledge management and information technology Planning, resource coordination and oversight Human resources management in WHO Budget and financial management Infrastructure and logistics Governing bodies External relations Direction									
Subtotal									
Exchange rate hedging Real Estate Fund Information Technology Fund Security Fund									
Grand total									

DETAILED ALLOCATION BY AREA OF WORK AND OFFICE (ASSESSED CONTRIBUTION[a] AND

Area of work	The Americas								
	Country			Regional			Total		
	Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing
Communicable disease prevention and control									
Communicable disease research									
Epidemic alert and response									
Malaria									
Tuberculosis									
HIV/AIDS									
Surveillance, prevention and management of chronic, noncommunicable diseases									
Health promotion									
Mental health and substance abuse									
Tobacco									
Nutrition									
Health and environment									
Food safety									
Violence, injuries and disabilities									
Reproductive health									
Making pregnancy safer									
Gender equality, women and health									
Child and adolescent health									
Immunization and vaccine development									
Essential medicines									
Essential health technologies									
Policy-making for health in development									

[a] Includes Miscellaneous Income.

ESTIMATE FOR TOTAL VOLUNTARY CONTRIBUTION), BY REGION, 2006-2007 (US$ THOUSAND)

Area of work	The Americas								
	Country			Regional			Total		
	Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing
Health system policies and service delivery Human resources for health Health financing and social protection Health information, evidence and research policy Emergency preparedness and response WHO's core presence in countries Knowledge management and information technology Planning, resource coordination and oversight Human resources management in WHO Budget and financial management Infrastructure and logistics Governing bodies External relations Direction									
Subtotal									
Exchange rate hedging Real Estate Fund Information Technology Fund Security Fund									
Grand total									

DETAILED ALLOCATION BY AREA OF WORK AND OFFICE (ASSESSED CONTRIBUTION[a] AND

Area of work	South-East Asia								
	Country			Regional			Total		
	Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing
Communicable disease prevention and control									
Communicable disease research									
Epidemic alert and response									
Malaria									
Tuberculosis									
HIV/AIDS									
Surveillance, prevention and management of chronic, noncommunicable diseases									
Health promotion									
Mental health and substance abuse									
Tobacco									
Nutrition									
Health and environment									
Food safety									
Violence, injuries and disabilities									
Reproductive health									
Making pregnancy safer									
Gender equality, women and health									
Child and adolescent health									
Immunization and vaccine development									
Essential medicines									
Essential health technologies									
Policy-making for health in development									

[a] Includes Miscellaneous Income.

ESTIMATE FOR TOTAL VOLUNTARY CONTRIBUTION), BY REGION, 2006-2007 (US$ THOUSAND)

Area of work	South-East Asia								
	Country			Regional			Total		
	Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing
Health system policies and service delivery									
Human resources for health									
Health financing and social protection									
Health information, evidence and research policy									
Emergency preparedness and response									
WHO's core presence in countries									
Knowledge management and information technology									
Planning, resource coordination and oversight									
Human resources management in WHO									
Budget and financial management									
Infrastructure and logistics									
Governing bodies									
External relations									
Direction									
Subtotal									
Exchange rate hedging									
Real Estate Fund									
Information Technology Fund									
Security Fund									
Grand total									

DETAILED ALLOCATION BY AREA OF WORK AND OFFICE (ASSESSED CONTRIBUTION[a] AND

Area of work	Europe								
	Country			Regional			Total		
	Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing
Communicable disease prevention and control									
Communicable disease research									
Epidemic alert and response									
Malaria									
Tuberculosis									
HIV/AIDS									
Surveillance, prevention and management of chronic, noncommunicable diseases									
Health promotion									
Mental health and substance abuse									
Tobacco									
Nutrition									
Health and environment									
Food safety									
Violence, injuries and disabilities									
Reproductive health									
Making pregnancy safer									
Gender equality, women and health									
Child and adolescent health									
Immunization and vaccine development									
Essential medicines									
Essential health technologies									
Policy-making for health in development									

[a] Includes Miscellaneous Income.

ESTIMATE FOR TOTAL VOLUNTARY CONTRIBUTION), BY REGION, 2006-2007 (US$ THOUSAND)

Area of work	Europe								
	Country			Regional			Total		
	Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing
Health system policies and service delivery Human resources for health Health financing and social protection Health information, evidence and research policy Emergency preparedness and response WHO's core presence in countries Knowledge management and information technology Planning, resource coordination and oversight Human resources management in WHO Budget and financial management Infrastructure and logistics Governing bodies External relations Direction									
Subtotal									
Exchange rate hedging Real Estate Fund Information Technology Fund Security Fund									
Grand total									

DETAILED ALLOCATION BY AREA OF WORK AND OFFICE (ASSESSED CONTRIBUTION[a] AND

Area of work	Eastern Mediterranean								
	Country			Regional			Total		
	Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing
Communicable disease prevention and control									
Communicable disease research									
Epidemic alert and response									
Malaria									
Tuberculosis									
HIV/AIDS									
Surveillance, prevention and management of chronic, noncommunicable diseases									
Health promotion									
Mental health and substance abuse									
Tobacco									
Nutrition									
Health and environment									
Food safety									
Violence, injuries and disabilities									
Reproductive health									
Making pregnancy safer									
Gender equality, women and health									
Child and adolescent health									
Immunization and vaccine development									
Essential medicines									
Essential health technologies									
Policy-making for health in development									

[a] Includes Miscellaneous Income.

ESTIMATE FOR TOTAL VOLUNTARY CONTRIBUTION), BY REGION, 2006-2007 (US$ THOUSAND)

Area of work	Eastern Mediterranean								
	Country			Regional			Total		
	Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing
Health system policies and service delivery Human resources for health Health financing and social protection Health information, evidence and research policy Emergency preparedness and response WHO's core presence in countries Knowledge management and information technology Planning, resource coordination and oversight Human resources management in WHO Budget and financial management Infrastructure and logistics Governing bodies External relations Direction									
Subtotal									
Exchange rate hedging Real Estate Fund Information Technology Fund Security Fund									
Grand total									

DETAILED ALLOCATION BY AREA OF WORK AND OFFICE (ASSESSED CONTRIBUTION[a] AND

Area of work	Western Pacific								
	Country			Regional			Total		
	Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing
Communicable disease prevention and control									
Communicable disease research									
Epidemic alert and response									
Malaria									
Tuberculosis									
HIV/AIDS									
Surveillance, prevention and management of chronic, noncommunicable diseases									
Health promotion									
Mental health and substance abuse									
Tobacco									
Nutrition									
Health and environment									
Food safety									
Violence, injuries and disabilities									
Reproductive health									
Making pregnancy safer									
Gender equality, women and health									
Child and adolescent health									
Immunization and vaccine development									
Essential medicines									
Essential health technologies									
Policy-making for health in development									

[a] Includes Miscellaneous Income.

ESTIMATE FOR TOTAL VOLUNTARY CONTRIBUTION), BY REGION, 2006-2007 (US$ THOUSAND)

Area of work	Western Pacific								
	Country			Regional			Total		
	Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing
Health system policies and service delivery Human resources for health Health financing and social protection Health information, evidence and research policy Emergency preparedness and response WHO's core presence in countries Knowledge management and information technology Planning, resource coordination and oversight Human resources management in WHO Budget and financial management Infrastructure and logistics Governing bodies External relations Direction									
Subtotal									
Exchange rate hedging Real Estate Fund Information Technology Fund Security Fund									
Grand total									

ALLOCATION BY AREA OF WORK AND OFFICE (ASSESSED CONTRIBUTION[a] AND

Area of work	Regions					
	Country			Regional		
	Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing
Communicable disease prevention and control Communicable disease research Epidemic alert and response Malaria Tuberculosis HIV/AIDS Surveillance, prevention and management of chronic, noncommunicable diseases Health promotion Mental health and substance abuse Tobacco Nutrition Health and environment Food safety Violence, injuries and disabilities Reproductive health Making pregnancy safer Gender equality, women and health Child and adolescent health Immunization and vaccine development Essential medicines Essential health technologies Policy-making for health in development Health system policies and service delivery Human resources for health Health financing and social protection Health information, evidence and research policy Emergency preparedness and response WHO's core presence in countries Knowledge management and information technology Planning, resource coordination and oversight Human resources management in WHO Budget and financial management Infrastructure and logistics Governing bodies External relations Direction						
Subtotal						
Exchange rate hedging Real Estate Fund Information Technology Fund Security Fund						
Grand total						

[a] Includes Miscellaneous Income.

ESTIMATE FOR TOTAL VOLUNTARY CONTRIBUTION), ALL LEVELS, 2006-2007 (US$ THOUSAND)

Total			Headquarters			GRAND TOTAL		
Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing