
Implementation of Programme budget 2012–2013: interim report

Report by the Secretariat

1. A mid-term review of implementation of the Programme budget 2012–2013 was conducted across the Organization as at 31 December 2012. The mid-term review process examines the progress made towards achievement of expected results and provides an overview of major successes, risks and issues in countries and in the work of the Secretariat. In addition, it focuses on lessons learnt and actions required to stimulate progress. Budget implementation was also reviewed, allowing for programmatic and financial implementation to be considered simultaneously.¹
2. The results of this review enable the Organization to build on successes, for example, scaling up specific initiatives, and to undertake corrective actions, including re-programming and allocating or reallocating resources to specific priority areas. The mid-term review is a self-assessment exercise that allows major offices to indicate whether their respective contributions to the expected results are on track, at risk or in trouble. Progress ratings reflect the extent to which programmes have delivered on their expected outputs and are progressing towards achieving the indicator targets. The lessons learnt and actions to be taken were documented at each level. Peer review and quality assurance elements were built into the process so as to ensure that progress was assessed in an objective and consistent manner.
3. The mid-term review identified the Organization-wide expected results that should be prioritized and the areas at risk of not meeting the targets by the end of the biennium.

OVERVIEW OF ORGANIZATION-WIDE EXPECTED RESULTS

4. Table 1 shows the progress made in achieving the Organization-wide expected results by strategic objective.² An “on track” rating implies that the rate of progress has been as foreseen up to the mid-term and is unlikely to alter significantly during the rest of the biennium. In general, for an expected result to register an “on track” rating, at least six of the seven major offices will have reported appropriate progress. An “at risk” rating means that progress towards achieving the relevant Organization-wide expected results is being affected by impediments and risks for which corrective action is required. If the contributions of two or more of the seven major offices have an “at risk” rating, this could call into question the achievement of the relevant expected results across the Organization by the end of the biennium. An “in trouble” rating implies that progress is being seriously hampered and it is unlikely that the Organization-wide expected result will be achieved.

¹ See document A66/29, Financial report and audited financial statements for the period 1 January 2012–31 December 2012.

² A detailed report of progress to the mid-term by strategic objective is available and will be provided on request.

5. Out of a total of 80 Organization-wide expected results for the biennium 2012–2013, 65 were considered to be “on track” (81%) and 15 “at risk” (19%). That represents an improvement in performance at this stage of the biennium over 2010–2011 when 30% of the Organization-wide expected results were rated as “at risk”.

6. All “at risk” expected results have been considered for follow-up action. Particular attention has been focused on the reasons progress is not on track and the actions required to minimize the risk to full achievement of expected results by the end of 2013. Technical and managerial follow-up actions include identification of priority results to which existing or future funding will be allocated or reprogrammed, identification of specific results that will not be delivered during the biennium or which will be postponed, and identification of specific plans to achieve efficiencies and cost reductions. As requested by Member States, such information has been included in the summary for each strategic objective in the main body of the report. More detailed information can be found in the full document “Implementation of Programme budget 2012–2013, Mid-term review”.¹

7. In 2012, the Secretariat undertook to address issues raised by Member States on the method of assessing achievement of expected results. For example, indicator definitions, baselines and targets have been reviewed and refined, and the distinction between outcomes (joint deliverables of Member States and Secretariat) and outputs (Secretariat deliverables) clarified.

8. Although improvements have been made in the review process, defining and monitoring appropriate performance measures, the self-assessment nature of the review, and the need for a clearer relationship between technical and financial performance continue to pose significant challenges. Many of these matters have been discussed with Member States and are being addressed in the draft programme budget 2014–2015 through a better delineation of Secretariat outputs and related indicators and the monitoring and evaluation framework.

¹ Document HQ/PRP/13.1 produced in English only and available on request.

Table 1. Progress rating by strategic objective

	Strategic objective	Organization-wide expected results			
		On track	At risk	In trouble	Total
SO1	To reduce the health, social and economic burden of communicable diseases	7	2	0	9
SO2	To combat HIV/AIDS, tuberculosis and malaria	4	2	0	6
SO3	To prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment	6	0	0	6
SO4	To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals	5	3	0	8
SO5	To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact	0	2	0	2
SO6	To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex	4	2	0	6
SO7	To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches	4	1	0	5
SO8	To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health	6	0	0	6
SO9	To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development	5	1	0	6
SO10	To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research	13	0	0	13
SO11	To ensure improved access, quality and use of medical products and technologies	3	0	0	3
SO12	To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system, and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work	4	0	0	4
SO13	To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively	4	2	0	6
Total		65	15	0	80

STRATEGIC OBJECTIVE 1: To reduce the health, social and economic burden of communicable diseases

9. Progress was made in introducing new and in promoting under-utilized vaccines. According to the latest available data,¹ *Haemophilus influenzae* type b (Hib) vaccine was introduced in nine additional countries, pneumococcal vaccine in 17 countries, rotavirus vaccine in three countries and human papillomavirus vaccine in 10 additional countries. Four out of five children worldwide (83% of an estimated total of 107 million) received the recommended three doses of diphtheria–tetanus–pertussis vaccine during infancy in 2011, demonstrating sustained progress over a two-year period. By the end of 2011, global coverage with measles vaccine had reached 84%. The year 2012 saw both the first World Immunization Week, with over 180 countries participating, and endorsement of the Global Vaccine Action Plan. Country reports containing key information on the performance of national immunization programmes, which is collected annually through the WHO/UNICEF joint reporting form, were received and the data validated and published. Measles mortality estimates for 2000–2010 were finalized and published in the *Lancet*. All 10 regional reference laboratories used for rotavirus diagnosis passed standard proficiency tests (laboratory external quality assessment). A total of 73 laboratories participating in the Invasive Bacterial Vaccine Preventable Diseases (IB-VPD) surveillance network were included in the external quality assessment, among which 47 passed the test (13 more than in 2011). Case-based, laboratory supported rash and fever surveillance was expanded to include 184 Member States in 2012.

10. By late 2012, all poliomyelitis outbreaks dating from 2011 in countries that are free from poliomyelitis had been halted and national emergency action plans were developed in the three remaining countries where poliomyelitis remained endemic (Afghanistan, Nigeria and Pakistan). In 2012, some 223 cases of poliomyelitis were reported globally, a 66% decline compared with 2011.²

11. The momentum in controlling neglected tropical diseases continued to gather force in 2012. WHO produced a “road map for implementation” in order to accelerate work in overcoming the global impact of neglected tropical diseases. In January 2012, publication of the London Declaration on Neglected Tropical Diseases strengthened the partners’ commitment to broadening access to medicines through larger pharmaceutical donations. Progress was made in the treatment of onchocerciasis, schistosomiasis and visceral leishmaniasis, as well as in developing a meningococcal A conjugate vaccine and rotavirus immunization schedules within the African meningitis belt. Vector control methods for dengue and human African trypanosomiasis were reinforced while advances were made in devising interventions for better prevention of dengue, research on Chagas disease, and general vector control research. The *Global Report for Research on Infectious Diseases of Poverty* was published and later launched at the Conference on Innovation in Healthcare without borders organized by the European Commission. The report focuses on innovation in health and explores new ways of improving public health in low- and middle-income countries through research. It highlights 10 reasons for carrying out research and a five-point action plan, which includes a proposal for an index of infectious diseases of poverty and multidisciplinary research within the context of the “one health one World” strategy.

12. Generic and specific tools to support countries in assessing the status of implementation of minimum core capacities required by the International Health Regulations (2005) were developed and disseminated. They included in-depth assessment protocols, specific assessment tools (including points

¹ Formal data are available with a one-year delay because of timelines for country reporting though the WHO/UNICEF Joint Reporting Form and data related consolidation and validation processes.

² See document A66/18.

of entry, laboratory, risk communications and legislation), monitoring checklists and States Party questionnaires. WHO supported the preparation of surveillance systems and laboratory networking, as well as the sharing of surveillance data and laboratory capacity. Support was also provided for strengthening capacity to detect, investigate and respond to events, including training in communications in the areas of behavioural impact, risk reduction and management of laboratory biosafety.

13. Work relating to specific diseases focused on influenza, dengue, Ebola, novel coronavirus, yellow fever, chikungunya, nodding syndrome (Uganda), hepatitis, cholera and meningitis. Technical support, including tools, guidelines and expert resources for investigation and control, was provided to countries that experienced outbreak events, with a total of 292 events managed in 2012 through the WHO Event Management System. Global and regional preparedness initiatives included stockpiling intervention materials, developing and refining both threat-specific and general preparedness plans, and issuing operational guidelines for detection, surveillance and response. In 2012, WHO began to collaborate with external partners on preparing strategies to contain antimicrobial resistance in health care and to foster global antimicrobial resistance surveillance. The revision of pandemic preparedness plans continues in many countries. Meeting International Health Regulations (2005) minimum core capacity requirements remains a challenge for most countries: 110 Member States have requested a two-year extension to the June 2012 deadline.¹ In order to accelerate implementation of the Regulations, four regional meetings were organized between partners, donors and States Parties to map unmet needs and create a collaboration and support network among Member States and donors to help countries in need to build the required core capacities. Member States have implemented regional strategies and employed the Regulations to detect, report and assess the risk of an outbreak. WHO and International Health Regulations National Focal Points have increased their use of the Event Information Site to share or access public health information on acute public health events.

14. Seven of the nine Organization-wide expected results are assessed as “on track”, while two are rated as “at risk”. Organization-wide expected result 1.2 (poliomyelitis eradication) was adversely affected by the threats to the security of vaccination teams in the Eastern Mediterranean and African Regions. Organization-wide expected result 1.6 (International Health Regulations core capacities) was undermined by the difficulty of meeting the minimum core capacity requirements in many countries. Enhanced resource mobilization efforts are planned at every level in order to support full implementation of Organization-wide expected results 1.6 (minimum core capacities) and 1.7 (detection, assessment and response to epidemic and pandemic-prone diseases).

15. In 2013, in the area of vaccines, WHO will provide high-level leadership, advocate for strong political and financial commitment and ensure effective collaboration with all stakeholders to sustain results and achieve the goals set out in the Global Vaccine Action Plan.² It will continue to identify and address constraints on safe immunization and service delivery in countries with low routine coverage, large numbers of un-immunized persons and equity gaps. Progress in poliomyelitis eradication is hindered by insecure environments: the recent attacks that killed poliomyelitis immunization workers in Pakistan and Nigeria have created unprecedented security challenges for programme implementation. To deal with this evolving situation, security access plans are being developed for each reservoir. At the international level, the programme is deepening its engagement and seeking enhanced support from the Organisation of Islamic Cooperation, the Islamic Development Bank and other Islamic institutions in terms of financial, technical and communications assistance both to inspire greater confidence in Muslim communities and constituencies and increase community

¹ See document A66/16.

² See document A66/19.

acceptance of the programme. It is planned to re-launch a regional grant programme for research on tropical diseases that will contribute to building local research capacity and help strengthen regional capability for harmonizing priorities and promoting targeted research in countries. The Organization will continue to build and strengthen the capacity of the Secretariat to perform fully and effectively the functions entrusted to it under the International Health Regulations (2005). While WHO will intensify its efforts to help countries in need in order to meet the minimum core capacities required by the International Health Regulations (2005) by June 2014, it will maintain its support for improving the detection, reporting and assessment of events and continue to monitor compliance with the Regulations worldwide. Timely and specific WHO support to countries in responding to public health emergencies – for which the availability of qualified staff and of a state-of-the art global system is essential – places continual demands on the Organization. The increasing challenges that arise from operating within a resource-constrained environment threaten to limit WHO's ability to respond effectively in the future.

STRATEGIC OBJECTIVE 2: To combat HIV/AIDS, tuberculosis and malaria

16. In 2012, Member States continued to expand access to HIV, tuberculosis and malaria prevention, diagnosis, treatment and care services. The number of people living with HIV who are on antiretroviral therapy continued to rise and had reached eight million by the end of 2011.¹ Since 1990, the tuberculosis mortality rate has fallen by 41%, and between 2000 and 2010 the malaria mortality rate fell by more than 25%. WHO's contribution towards achievement of the strategic objective covered policy guidance, technical support, capacity building, and monitoring and evaluation. The Global health sector strategy on HIV/AIDS 2011–2015 has been adapted in all regions, and guidance was provided on the use of antiretroviral therapy in HIV prevention and in the prevention of mother-to-child transmission of HIV. In the normative and policy areas related to tuberculosis, WHO's work covered: contact investigation and screening; HIV-associated tuberculosis; integration of actions to combat tuberculosis into the work of nongovernmental and other civil society organizations; childhood tuberculosis; and laboratory biosafety. The Global Malaria Programme issued guidance on seasonal malaria chemoprevention for highly seasonal transmission in the Sahel subregion of Africa and updated policies on intermittent preventive treatment of malaria in pregnancy and the use of single dose primaquine.²

17. With its partners, WHO worked to broaden access to new diagnostics and medicines, and other products, for example, rapid diagnosis of tuberculosis and drug-resistant tuberculosis in 77 countries. The *World malaria report 2012* and the *Global tuberculosis report 2012* presented the latest data on the state of the malaria and tuberculosis epidemics. Challenges for the future include, financing further progress in an environment in which there may be less donor support, and the emergence of multidrug resistance to treatments used against tuberculosis and malaria. Priorities for 2013 include: in the area of HIV: publication of consolidated guidelines on the use of antiretroviral therapy and provision of support for their implementation; in the area of tuberculosis: development of the post-2015 strategy and targets, and policy guidance on the introduction of new drugs for the first time in 40 years; and in the area of malaria: implementation of the emergency response to contain artemisinin resistance in the Greater Mekong subregion programme, and maintaining coverage with long-lasting insecticidal bednets.

18. Four of the six Organization-wide expected results are assessed as “on track” and two, namely, Organization-wide expected result 2.1 (prevention, treatment and care for HIV/AIDS, tuberculosis and malaria) and Organization-wide expected result 2.6 (new knowledge, intervention tools and strategies

¹ The latest data available is for 2011.

² See document A66/21.

developed), as “at risk”. WHO’s capacity to support the adoption and implementation of policies is “at risk” because of resource and capacity constraints in countries, including inadequate allocation of resources for the diagnosis and treatment of sexually transmitted infections in the Region of the Americas and the Western Pacific Region. For Organization-wide expected result 2.6 (new knowledge intervention tools and strategies), the Regional Office for Africa and the Regional Office for the Eastern Mediterranean indicate that a lack of capacity in the Secretariat and financial support is impeding progress in promoting specific research.

19. In 2013, in order to escalate progress against Organization-wide expected result 2.1, WHO will continue to invest in advocacy, technical support and resource mobilization for action against HIV, tuberculosis and malaria. Financing for all three diseases is causing increasing concern because of the uncertainties facing the Global Fund to Fight AIDS, Tuberculosis and Malaria and bilateral donors. For Organization-wide expected result 2.6, WHO will increasingly focus on prioritization of the research agenda and collaboration with external organizations in order to support research.

STRATEGIC OBJECTIVE 3: To prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment

20. In 2012, Member States reached consensus on the global monitoring framework for noncommunicable diseases, including indicators and nine voluntary global targets. The Sixty-third session of the Regional Committee for the Western Pacific adopted resolution WPR/RC63.R3 on Violence and injury prevention. Priority was given to supporting countries in scaling up national programmes, and to strengthening the political, financial, and technical commitment of Member States in preventing and controlling noncommunicable diseases and preparing relevant policies, strategies and regulations. Some countries have enhanced their risk factor surveillance, scaled up interventions to reduce exposure to them, and adopted a primary health-care approach to preventing and managing noncommunicable diseases.

21. The Mental Health Gap Action Programme is being scaled up across all regions, and the WHO QualityRights project and toolkit designed to improve conditions and human rights in mental health facilities were launched and are being implemented in countries. Member States were also supported to adopt evidence-based policies, strategies and regulations in the area of mental health and substance abuse. A number of documents, including, *Dementia: a public health priority*, were published. The report reveals that the number of people living with dementia worldwide, currently estimated to be 35.6 million, will double by 2030 and more than triple by 2050. The report also describes the impact of dementia on individuals and society, as well as different national approaches to tackling dementia, considers issues around care-giving and care-givers and discusses ways of increasing awareness and advocating for dementia.¹

22. Progress was also made in improving road traffic safety, as evidenced by the increase in seat belt and helmet use. Several national and regional capacity-building workshops and training sessions were conducted on trauma care, violence prevention and road traffic safety. A total of 60 countries have so far hosted policy discussions on the *World report on disability 2011*. In November 2012, the first World Congress on Community Based Rehabilitation brought together 1500 experts and practitioners to share best practice and plan the next steps for work in this area.²

¹ See document A66/10.

² See document A66/12.

23. With support from the Secretariat, two additional countries are providing either free or partially free tobacco cessation support through primary health-care services in conjunction with their implementation of the WHO Framework Convention on Tobacco Control.

24. All six Organization-wide expected results are on track. Some activities were delayed, such as publication of the *Global status report on road safety 2013* because further data analysis was required.

25. Advocacy by WHO and its partners has had a noticeable impact. In general, WHO is gradually moving from advocacy and normative guidance to supporting implementation in 2013. Activities that will not take place in 2013 include, a global meeting of ministry of health focal points for violence and injury prevention, and an assessment of prevention and treatment systems for substance-use disorders as current resources will be used for other priorities. Other activities, such as strengthening the engagement of WHO collaborating centres in the implementation of mental health projects, and the creation of a network on child injury prevention, will be carried out in a different manner, for example by leveraging external resources and partners.

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

26. In the political arena, the momentum continued towards attainment of Millennium Development Goals 4 (Reduce child mortality) and 5 (Improve maternal health).¹ Under the umbrella of the United Nations Secretary-General's Global Strategy for Women's and Children's Health, the United Nations Commission on Life-Saving Commodities for Women and Children was established and made recommendations for increasing the availability, affordability, accessibility and rational use of selected life-saving commodities. By the end of 2012, a total of 72 countries had developed or updated their strategies on universal access to effective interventions for improving maternal, newborn and child health, and technical support had been provided for developing or revising relevant policies and strategies in countries.² In addition, 63 countries now have a policy on universal access to sexual and reproductive health.

27. Capacity-building workshops on, inter alia, maternal death surveillance and response, were conducted with the participation of more than 70 countries as part of the process of implementing the recommendations of the Commission on Information and Accountability for Women's and Children's Health. Countdown to 2015, which tracks progress towards achievement of Millennium Development Goals 4 and 5, published its 2012 report. WHO serves on its coordinating committee. Countries in all regions were supported to revise or update their road maps and plans for accelerating reduction of maternal, new-born and child mortality, and to build capacity in strategic planning, including cost and impact analysis using the OneHealth tool. Progress was made in building the capacity of national experts in operational research. Guidelines on improving the quality of care of mothers, newborns and children have been prepared or updated and disseminated in countries. The drafting of policies on adolescent health was supported in 15 countries, and new settings, for example, schools, are being sought. The theme of World Health Day 2012 was healthy ageing; the availability of information on ageing through new web pages, fact sheets and guidelines has sparked interest in around 20 countries.

¹ See document A66/13.

² See document A66/14.

28. Five of the eight Organization-wide expected results are on track, but three are rated as “at risk”. Organization-wide expected result 4.2 (national research capacity strengthened) is a priority area and despite the current funding gaps, the regional offices for Africa, the Eastern Mediterranean and Europe and headquarters have endeavoured to maintain previous commitments and fund some research. A shortage of both financial and human resources for Organization-wide expected result 4.6 (Adolescent health) has had a particular impact on the provision of systematic support to countries, including for adolescent-friendly health services. In the case of Organization-wide expected result 4.7 (Reproductive health), WHO’s normative work in family planning is progressing, but other areas, such as sexually transmitted infections, have not attracted specified donor funding.

29. In order to make progress towards the achievement of Millennium Development Goals 4 and 5 by the 2015 deadline, WHO will need to intensify its joint work with the H4+ partnership (UNAIDS, UNFPA, UNICEF, UN Women and the World Bank). In addition, resource mobilization for underfunded areas, such as healthy ageing and sexually transmitted infections, will be undertaken in 2013. WHO will strengthen the technical capacity of its country offices and address the financial and human resource constraints impeding achievement of the three Organization-wide expected results, particularly adolescent health programmes, by leveraging other resources including collaborating centres and consultants.

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

30. Progress was made in building the preparedness and response capacities of Member States, heightening WHO’s readiness, and coordinating health sector response and recovery services in humanitarian emergencies.¹ For Organization-wide expected result 5.1 (strengthening national emergency preparedness plans), the Secretariat provided support to Member States across all regions for developing disaster and emergency risk management programmes, building their emergency response capacities, and making health facilities more resistant and resilient. The support offered covered: chemical, radiological and environmental hazards; safe hospitals; preparedness, including for the Olympic Games in London in August 2012; urban emergency management in Maldives and Myanmar; and the establishment of emergency operations centres in the Lao People’s Democratic Republic and Mongolia. WHO also provided training materials, guidance and tools for enhancing preparedness and assessing risk management capacity, and hospital preparedness training kits for evaluating health system capacities. In order to scale up its institutional readiness, the Organization established the Global Emergency Management Team, conducted an Organization-wide emergency simulation exercise, developed the Emergency Response Framework (setting out WHO’s commitments, including standards against which to measure performance and policies for optimizing a timely and effective response) and created a mechanism for setting up quarterly on-call emergency surge teams.

31. For Organization-wide expected result 5.7 (operations and response to emergencies and disasters), in emergency response situations Member States are increasingly taking the lead in coordinating international humanitarian actors, overseeing service delivery and offering essential health services. WHO focused its efforts on providing more timely and effective support to Member States and partners in the following areas: leadership and coordination of the health cluster and the health sector; needs assessments; strategic planning; information bulletins; social communications; surveillance and early warning systems; technical assistance, and other commitments as outlined in the Emergency Response Framework. During 2012, WHO responded to a total of 36 acute and

¹ See document A66/27, section D.

22 protracted emergencies, demonstrating a stronger performance, particularly in the Syrian Arab Republic, where emergency staff were deployed, a health sector strategy prepared, an appeal organized and an emergency support team established in Amman.

32. Despite the progress made, both Organization-wide expected results are considered to be at risk. In the case of Organization-wide expected result 5.1 (national emergency preparedness plans and programmes), changes to the Organization-wide expected results for the biennium were not accompanied by a corresponding shift in the priorities of some regional offices, which slowed progress towards achievement of the indicators for risk management assessment at national level and emergency simulation exercises at national and country office level. The recent restructuring and redirection activities at headquarters prevented completion of global normative products, such as the global risk assessment tool. Furthermore, indicator targets were unrealistically high given the recent radical shift in WHO's emergency work, and human and financial resources for core staff and activities were insufficient for achieving the indicator targets.

33. Organization-wide expected result 5.7 (operations and response to emergencies and disasters) is considered to be "at risk" because of the slow response to the crisis in the Sahel region of Africa and WHO's poor performance in the Central African Republic, Myanmar and countries directly affected by the crisis in the Syrian Arab Republic. Such weaknesses were at least partly caused by the low level of funding for response activities (less than 30% against response appeals or US\$ 227 million out of US\$ 744 million requested).

34. In 2013, WHO will support emergency risk management activities by working with priority countries and partners to: put health at the centre of national emergency and disaster management plans and intersectoral programmes; increase national self-reliance and resilience through national emergency operations centres, surge teams, response plans and training for national responders; and finalize the global emergency and disaster risk-management framework and related guidance. In order to strengthen the support it gives Member States to enhance their emergency response capability, WHO will: devise health indicators to measure the impact of intersectoral responses to humanitarian emergencies; finalize and apply the readiness checklist across all three levels of the Organization; complete the emergency support team manual and update the standard operating procedures; establish quarterly on-call surge teams in all major offices; conduct annual simulations; and track performance in emergency response. At the same time, WHO will prioritize staff, activities and locations for this work, and allocate its limited core resources accordingly, while mobilizing increased donor and partner support. Efforts will be focused on two of the indicators pertaining to national risk management capacity assessments and WHO readiness. During emergencies, WHO will continue to implement its Emergency Response Framework, promote partnerships, prioritize its role as health cluster lead agency, and standardize and improve the quality of project design, management and reporting.

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

35. In 2012, the global monitoring framework, including indicators and a set of voluntary global targets for the prevention and control of noncommunicable diseases, was drawn up and guidance given to Member States on strengthening surveillance of noncommunicable diseases. It covers harmful use of alcohol, unhealthy diet, physical inactivity and tobacco use, as well as raised blood pressure and

blood glucose levels, and anthropometric measures.¹ Other aspects of the noncommunicable disease burden, such as mortality, morbidity and the capacity of Member States to respond, are included in the reporting on strategic objective 3.

36. By the end of 2012, 53 Member States reported that they were preparing a written national alcohol policy and 39 Member States reported that they were reformulating existing policies for reducing the harmful use of alcohol. In February 2012, WHO co-hosted the Global Alcohol Policy Conference with the theme “From the global alcohol strategy to national and local action”. The WHO global survey on alcohol and health was conducted in collaboration with Member States, and data on alcohol consumption, alcohol-related harm and policy responses were collected from 178 countries covering 98% of the world’s population. Analysis of the data began in 2012 and will be completed in 2013. The results will be presented in the next update of the *WHO global status report on alcohol and health*. Two global information systems and their regional versions were further developed, updated and integrated in the Global Health Observatory, namely, the global information system on alcohol and health and the global information system on resources for the prevention and treatment of substance use disorders.²

37. Significant advances continued to be made in the technical implementation of the WHO Framework Convention on Tobacco Control, which now has 176 States Parties. WHO works with all Member States to implement effective and efficient selected tobacco demand reduction measures. Fifty-one of the 194 WHO Member States (representing only 7% of the world’s population) do not yet have reliable estimates of tobacco use. Tobacco taxes equal to more than 75% of the price of a packet are levied in 29 countries; 42 countries have 100% smoke-free legislation covering all public places; in 30 and 62 countries, graphic health warnings cover at least 50% and 30%, respectively, of the package surface.

38. During the first half of the biennium, advances were made in the areas of childhood obesity prevention, population salt/sodium reduction and promotion of physical activity. Examples of specific measures include, multisectoral capacity building to support Member States in setting priorities in policies on childhood obesity, marketing of foods to children and promotion of physical activity. Capacity building was carried out at regional and country level in the Region of the Americas and the African, European and Western Pacific regions through workshops in which representatives of relevant ministries, such as agriculture, sport and recreation, and education participated.

39. The capacity of countries to use data collection tools and systems, including data on sexual behaviour, was strengthened. WHO worked with partners in support of the Family Planning Summit 2012, whose aim was to meet contraceptive needs in countries with the highest gaps, and to promote safer sexual behaviour.

40. Overall, four of the six Organization-wide expected results are on track and two, Organization-wide expected result 6.5 (unhealthy diets and physical inactivity) and 6.6 (new knowledge intervention tools and strategies), are at risk. The Regional Office for the Americas and headquarters reported that the indicators for the adoption of multisectoral strategies and plans for healthy diets and physical activity by Member States are at risk because of weak political commitment in some countries. Organization-wide expected result 6.6 is at risk because of slow implementation rates in the South-East Asia and European regions as a result of a shift in priority setting and limited financial resources, respectively.

¹ See document A66/8.

² See document A66/27 section B.

41. Priorities for 2013 are full implementation of both the global action plan for the prevention and control of noncommunicable diseases 2013–2020 and the global monitoring framework. Actions to tackle the four noncommunicable disease risk factors, alcohol, unhealthy diet, physical activity and tobacco use, will focus on the implementation at country level of specific measures to reduce risk factors and on engaging with both multisectoral (whole of government) and multistakeholder (nongovernmental organization) players.

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

42. The World Conference on Social Determinants of Health, held in October 2011, and the subsequent adoption of resolution WHA65.8 endorsing the Rio Political Declaration on Social Determinants of Health, served both to move social determinants of health up the political agenda and to increase demand from Member States for technical support. Data from May 2012 shows that 84 country cooperation strategies included requests for technical support for implementing a “health-in-all-policies” approach.¹ The current demand exceeds the Secretariat’s capacity to respond. A growing perception among Member States of the risks of not addressing ethical issues of global concern creates expectations that go beyond the current budget allocations and resources. The monitoring of disaggregated data on health inequities also faces challenges within and across countries.

43. National strategies to address social determinants of health and health inequities were prepared in, inter alia, Chile, Costa Rica, Hungary, India, Islamic Republic of Iran, Mexico and Norway. National consultations on the post-2015 development agenda clearly identify social determinants of health as the main bridge between health and other sectors.

44. In the discussions on WHO reform, the social, economic and environmental determinants of health were identified as one of the six leadership priorities for the draft twelfth general programme of work 2014–2019. The Health 2020 policy framework was adopted by the Regional Committee for Europe at its Sixty-second session. Its aim is to significantly improve the health and well-being of populations and reduce health inequalities.

45. In the area of ethics, the EU Clinical Trial Register, recognized as the primary WHO registry, was expanded, and the International Clinical Trials Registry Platform database now contains information on more than 220 000 trials. In 2012, a total of 90 national ethics committees participated in the 9th Global Summit of National Ethics Committees, which addressed ethical issues, including advanced research, biobanking and organ, tissue and cell transplantation.

46. Efforts are being made to mainstream gender, equity and human rights across the three levels of the Organization, and a global focal point network that builds on existing gender, equity and human rights networks has been created across all six WHO regions.²

47. Four of the five Organization-wide expected results are “on track” and one, Organization-wide expected result 7.3 (social and economic data relevant to health) is “at risk” because the Regional Office for the Eastern Mediterranean and the Regional Office for South-East Asia reported

¹ See document A66/15.

² See document A66/27, section K.

experiencing difficulties in generating, disaggregating, analysing and translating data. However, with a concerted effort, it should be possible to publish the four additional country reports incorporating disaggregated data and analysis of health equity during the biennium.

48. The Secretariat is exploring ways of working with multilateral and bilateral partners to meet the demand for capacity-building support in 2013 and beyond.

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

49. Global and regional efforts to address environmental and occupational determinants of health have continued, as has normative work on environmental threats to public health. Data on the global burden of disease are widely used by countries and international organizations, including WHO, in supporting policies and setting priorities designed to improve health through targeted actions. Millennium Development Goal targets for water and sanitation have been achieved; since 1990, more than two billion people have gained access to improved drinking-water sources. The fourth edition of the *WHO Guidelines for drinking-water quality* continues to serve as an international reference point for the development of policies and regulations. A survey conducted in 2011 showed that 73% of 42 responding Member States use the Guidelines. Another survey conducted in 2012 showed that 72% of 46 responding countries, mainly in sub-Saharan Africa, had national policies on household water treatment and safe storage.¹

50. WHO has become a partner in new global initiatives on access to energy, short-acting air pollutants and clean cookstoves. A strategy for strengthening the engagement of the health sector in implementation of the Strategic Approach to International Chemicals Management, prepared by WHO, was adopted by the International Conference on Chemicals Management in September 2012.

51. The Workers' health: global plan of action (resolution WHA60.26) continued to be implemented worldwide with the support of the WHO Global Network of Collaborating Centres in Occupational Health.²

52. After the Fukushima nuclear accident in March 2011, WHO initiated a formal health risk assessment to examine the consequences of the accident, starting with a preliminary radiation dose estimate for the general population, which was published in May 2012. WHO engaged in UN-Energy activities and in the United Nations Secretary-General's Sustainable Energy for All initiative. The Organization provided technical support to countries for interventions to address health issues related to air quality, as well as support to Member States on adaptation to climate change, with particular emphasis on strengthening health systems.

53. All six Organization-wide expected results are "on track" for 2012–2013. Nevertheless, more than 40% of countries have indicated their inability to meet the minimum core capacity requirements of the International Health Regulations (2005) in the area of chemicals (the figure is higher in the African and Eastern Mediterranean Regions). In order to provide the necessary support for capacity building, the search for additional sources of funding will be scaled up in 2013. Indeed, since October 2012, resource constraints have prevented WHO providing a staff member to the Strategic Approach

¹ See document A66/27 section I.

² See document A66/27 section J.

to International Chemicals Management secretariat. WHO will strengthen its efforts to engage new partners in the field during the remainder of the biennium, for example through the WHO–UNEP Global Alliance to Eliminate Lead in Paints, activities supporting implementation of the Minamata Convention on Mercury, and the establishment of a WHO chemical risk assessment network.

54. In 2013, only limited funding is currently available for gathering data on the burden of disease in the area of public health and the environment, and new sources will be sought to facilitate the updating of figures. In response to the growing number of requests for technical support from countries, WHO will continue to devise activities in connection with access to energy, short-acting air pollutants and clean cookstoves. It will also continue to seek the necessary financial resources.

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

55. WHO estimates that foodborne and waterborne diarrhoeal diseases together kill about 2.2 million people annually, 1.9 million of whom are children. Contaminated complementary foods and water cause up to five episodes of diarrhoea per child per year in the African Region. Food contamination also contributes to the burden of noncommunicable diseases, in particular cancer and cardiovascular diseases, and can also affect reproductive health and the immune system.

56. The Sixty-fifth World Health Assembly endorsed a comprehensive implementation plan for maternal, infant and young child nutrition, which provides a clear set of action priorities for the Secretariat, Member States and development actors. The plan identified six global nutrition priorities to be achieved by 2025, which can be broadly described as follows: reducing stunting and wasting in children under five while halting the epidemic of childhood overweight; reducing both anaemia in women of reproductive age and low birth weight; and to increase exclusive breastfeeding.¹ The Regional Committee of the Western Pacific Region, at its Sixty-third session, considered how best to accelerate progress towards achievement of global nutrition targets in the Region, including through the development of country action plans.

57. The importance of a healthy diet is also at the centre of the new action plan on noncommunicable diseases to be discussed by the Sixty-sixth World Health Assembly. A draft nutrition action plan 2013–2020 for the European Region has been prepared. Many countries have updated their national nutrition strategies and action plans to address under-nutrition and overweight. New guidelines have been developed on vitamin and mineral supplementation and on the management of malnutrition. Based on the scientific advice provided jointly by FAO and WHO, the Codex Alimentarius Commission devised over 400 international food safety standards, as well as guidance, which serve as the core of the joint FAO/WHO food standards programme.

58. The WHO child growth standards have been adopted in more than 115 countries (five new countries in 2012). In the African Region, initiatives to strengthen nutrition surveillance in 11 countries and to scale up interventions aimed at women and children were launched. In the European Region, the Childhood Obesity Surveillance Initiative was extended and a partnership was formed with the European Commission to produce an information system covering nutrition, physical activity and obesity. Several regions have been tackling the nutrition risks that can cause noncommunicable diseases: reducing salt and fat intake in the Eastern Mediterranean Region; and improving school meals, controlling marketing of food to children and reducing salt intake in the

¹ See resolution WHA65.6 and Annex 3.

European Region. In the Region of the Americas, five countries have been monitoring compliance with the International Code of Marketing of Breast-milk Substitutes, and Mexico now has a policy on breastfeeding. Member States have been supported to review their food safety legislation and in building and maintaining capacity to manage food safety events as required by the International Health Regulations (2005). The International Food Safety Authorities Network (INFOSAN) now comprises 178 Member States. Regional groupings and interest groups are linking up with Member States to exchange information on best practices and problems through a web-based platform.

59. Global dietary patterns have shifted towards higher and unhealthy consumption of saturated fats, salt and sugars, while food insecurity still affects a large part of the world's population as a result of price volatility and environmental factors. The increasing burden of nutrition and food-safety related diseases, with both under-nutrition and overweight appearing simultaneously in many countries, has attracted global attention. However, adequate resources have not always been made available. Of the six Organization-wide expected results, five are "on track" and one, Organization-wide expected result 9.5 (foodborne diseases and food hazards prevention and control) is "at risk". The Regional Offices for Africa and the Americas reported that they might be unable to provide technical support for preparing food safety policies and programmes.

60. In the second half of the biennium, WHO will focus on the comprehensive implementation plan for maternal, infant and young child nutrition, by supporting Member States in setting up programmes to reduce stunting, wasting and women's anaemia, as well as and reducing the prevalence of overweight in children, which has reached epidemic proportions. In addition, WHO will strengthen national food safety systems through international harmonized standards and increased cross-sectoral collaboration.

STRATEGIC OBJECTIVE 10: To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research

61. The strategic objective addresses the constraints facing countries as they seek to move towards universal health coverage, for example, the impact on countries' finances of the extended economic downturn, lack of investment in health infrastructure, and a crowded yet fragmented global public health arena that does not always align with countries' individual priorities. WHO's work focuses on supporting countries in addressing questions relating to: health service availability, quality and regulation; health workforce availability, distribution, quality and performance; information and research for timely, evidence-based decision making, including e-health; health financing strategies for universal health coverage; governance and regulation across the health sector; the policy dialogue around national health plans and strategies, which ties all the components together; and donor coordination linked to the International Health Partnership (IHP+). In 2012, national health strategies and plans were reviewed or updated in 43 countries and a major effort was made to support countries across the entire health system. A total of 31 countries established donor coordination mechanisms in order to strengthen national plans and strategies; 29 countries updated their legislation and regulatory frameworks; 80 countries received technical and policy support for health financing within the ambit of universal health coverage; 43 countries made progress in implementing service delivery models based on a primary health-care approach; 55 countries improved the completeness, timeliness and quality of their health information systems as evidenced by improved reporting of health data and stronger statistical country profiles; and 56 countries developed accountability frameworks and road maps as a follow-up to the recommendations of the Commission on Information and Accountability for Women's and Children's Health.

62. Progress has been made in training and retaining health workers and in tackling distribution and skills mix issues. A total of 22 countries across all regions expanded their health workforce, and 32 out of the 52 countries that reported began implementing the WHO Global Code of Practice on the International Recruitment of Health Personnel. However, introduction of the Code still needs to be expanded through incorporation in information platforms, such as the regional and national health workforce observatories.¹ Countries are expanding their use of information and communications technologies within health systems, with particular emphasis on different aspects of eHealth, including electronic medical records, telemedicine, and eLearning. Key developments in countries took place in the areas of mobile health (mHealth), telemedicine and use of the Internet for health purposes. In 2012, a knowledge portal was launched listing 80 countries that have developed eHealth policies, strategies and regulatory frameworks, as well as knowledge management strategies. Access to biomedical and health literature through the Health InterNetwork Access to Research Initiative (HINARI) was expanded, including to 41 African countries. Agreement was reached with a publishing partner to make over 12 000 online books available in countries with a functioning HINARI programme. The second Global eHealth Survey was completed with the participation of 114 countries, and six reports were published. WHO and ITU jointly completed and launched an eHealth strategy toolkit. The Forum on Health Data Standardization and Interoperability was established and the HINARI Public Private Partnership extended to 2020.²

63. Across WHO, all Organization-wide expected results are “on track” In 2013, the Secretariat will respond to the growing number of requests for technical and policy support from Member States, partly triggered by publication of the *World health report 2010* and the momentum it generated for universal health coverage. Increases in specified funding have been received primarily for developing the policy dialogue on national health strategies and plans, financing for universal health coverage, and follow-up activities associated with the Commission on Information and Accountability for Women’s and Children’s Health, including work on information systems, country compacts and tracking expenditure. WHO is, however, currently reviewing elements of the strategic objective that are not so well funded, for example, patient safety.

64. In 2013, a sharper focus will be directed towards activities related to patient safety research, small grants programmes and the first and second WHO Global Patient Safety Challenges. In headquarters, all health system components have been reorganized in order to allow further prioritization in 2013 and to achieve cost efficiencies.

STRATEGIC OBJECTIVE 11: To ensure improved access, quality and use of medical products and technologies

65. Nearly half the total expenditure of Member States is on medical products, yet people die every day as a result of lack of access to quality-assured health commodities because of high prices, their inability to pay, absence of social protection, inefficient supply management, and weak regulatory and enforcement systems. Many countries have limited capacity for research and development and innovation, which further impedes progress in tackling diseases. WHO is coordinating efforts to strengthen the financing and coordination of research and development in order to meet the health needs of developing countries. It is exploring the proposal made by the Consultative Expert Working Group in 2012 to establish an observatory in order to better monitor and analyse information on health research and development.

¹ See document A66/25.

² See document A66/26.

66. Improving access to essential medicines and medical products that are affordable and quality assured is a prerequisite for achieving universal health coverage, increasingly seen as critical to delivering better health care, and as a unifying goal for health system development. WHO continues to support countries in preparing or updating policies on medicines and other medical products and in adapting them to national priorities and contexts, taking into account global trends in policy and research. Guidance on improving national policies on pricing medicines throughout the supply chain is about to be published, and the WHO Model Formulary, the authoritative guide on how to make effective use of the medicines in the WHO Model List of Essential Medicines, is now available and countries are encouraged to adapt it to their individual needs. The National Formulary of India has been made into a mobile phone application and has been downloaded by 50 countries in addition to India. a mobile phone application and has been downloaded by over 50 countries. There is also growing regional interest in evidence-based selection and use of medicines and the WHO Medicines Safety Programme database receives over eight million adverse drug reaction reports annually. Pharmaceutical sector profiles have been endorsed by 130 countries, and WHO's growing body of work on improving the transparency of medicines and good governance has had an impact in about 20 countries. The Expert Committee on Drug Dependence met and reviewed substances for possible scheduling under the International Drug Control Treaties – a critical function laid down for WHO in the Treaties. A lack of funds had prevented the Committee from meeting for six years.

67. The Member State mechanism on substandard/spurious/falsely-labelled/falsified/counterfeit medical products held its first meeting in November 2012, with WHO acting as its secretariat.¹ WHO also fosters collaboration among regulatory authorities and the harmonization of regulatory standards across regions, and coordinates the regulation of herbal medicines. A national regulatory authorities' strategic plan for vaccines will soon be launched in order to support countries in strengthening their vaccine regulatory capacity (assessed as functional in 35 countries). In 2012, WHO prequalified nine diagnostics, six vaccines, 47 medicines, 21 active pharmaceutical ingredients and four quality-control laboratories. It also provided 34 written and physical standards for medicines, including 18 new global monographs and texts for inclusion in the International Pharmacopoeia, and 10 new international chemical reference standards. Six new quality assurance guidelines adopted by the WHO Expert Committee on Specifications for Pharmaceutical Preparations were published. The Expert Committee on Biological Standardization provided 19 new or replacement international biological reference materials, and six new or replacement written standards to ensure the quality, safety and efficacy of vaccines. In addition, 163 proposed and 115 recommended International Nonproprietary Names for medicines were made available.

68. WHO organized the first global meeting on improving access to safe blood products and reducing the current wastage of human plasma. In order to improve traceability, vigilance and surveillance in organ transplants, two tools were launched: a project entitled, "Standardization of organ nomenclature globally" and the Notifylibrary database. Under the leadership of the Safe injection global network, progress was made in improving injection safety; through a reduction both in the number of injections and the reuse of injection devices, the number of unsafe injections fell by 88% between 2000 and 2010.²

69. All three Organization-wide expected results are on track. The Regional Office for the Eastern Mediterranean will further scale up its efforts to make progress on Organization-wide expected result 11.1 (policy on essential medical products and technologies) and 11.3 (use of medical products and

¹ See document A/MSM/1/4.

² Latest data available.

technologies). Financial constraints arising from the earmarking of funds for specific activities and ongoing political instability in most countries in the Region have slowed progress and prevented the necessary changes being made as expected during the first year of the biennium. The work undertaken to improve the availability of quality assured medical products and stimulate research and innovation has a direct impact on all other strategic health outcomes in WHO, therefore, close collaboration with other strategic objectives will continue.

70. In 2013, priority will be given to strengthening global advocacy for core functions and collaboration with countries; strengthening collaboration with regulatory authorities for access to safe, high-quality and well-regulated medical products; and streamlining the prequalification programmes. Priority will also be given to improving access to medical products in order to achieve universal health coverage; mobilizing resources for WHO's work on medicines, quality norms for blood and blood products and cell, tissue and organ transplantation; promoting the rational selection and use of medicines using health technology assessment approaches; and combating anti-microbial resistance. In addition, WHO will continue to facilitate Member States' discussions, and to follow up its work both on substandard/spurious/false-labelled/counterfeit products, and that linked to the report of the Consultative Expert Working Group on Research and Development.¹

STRATEGIC OBJECTIVE 12: To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system, and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work

71. During 2012, work continued on programme, governance and managerial reform. Programme priority setting for global health for 2014–2019 was guided by a Member States' led process, conducted in February 2012, and consensus was built around key areas of WHO's work. Further advances were made in reforming governance and Member States endorsed the revised terms of reference for the Programme, Budget and Administration Committee.² Criteria for harmonizing the nomination and selection processes for regional directors were also endorsed. Work on enhancing strategic decision making by governing bodies and effective engagement with partners and other stakeholders continued to make progress. In December 2012, the extraordinary session of the Programme Budget and Administration Committee discussed the future financing of WHO.³ The evaluation policy articulated in resolution WHA64.2 was adopted by the World Health Assembly, and the first stage of the independent evaluation of internal governance was completed and reported.⁴

72. The Global Policy Group⁵ continued to guide the internal governance of the Organization. Regional offices promoted the active engagement of Member States in the preparation of regional committees and other high-level meetings and their participation in them. Work on strategic partnerships continued in order to strengthen collaboration with different partners, some of which were hosted by WHO, or, inter alia, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the GAVI Alliance, the European Union and United Nations organizations and agencies.

¹ See document A66/23.

² Resolution EB131.R2.

³ See document EB132/3.

⁴ Document A65/5 Add.2.

⁵ The Global Policy Group is composed of the Director-General, Deputy Director-General and the six regional directors.

73. Work on strategic communications continued with a global stakeholder perception survey conducted for the first time. The recommendations of the survey will drive the communications strategy, facilitate closer collaboration between offices and establish the baselines and targets for measuring progress in the future. Strategic communications were further enhanced through the development of multilingual web sites and timely publication of news and information products. Progress was made in the provision of health literature and in improving online access to up-to-date information resources in the regions. Training sessions were conducted to further build the health communications skills of regional and country personnel.

74. The introduction of a competitive selection process and a global roster of Heads of WHO offices in countries, territories and areas has strengthened the recruitment process. The quality of the country cooperation strategies has improved progressively and their use has increased. The global country cooperation strategies analysis, conducted in 2012, showed that more WHO offices were using the strategies in planning, advocacy and resource mobilization: a total of 90% in 2012 compared to 80% in 2010. Innovative approaches for networking among WHO country offices were initiated in the BRICS grouping of Brazil, Russian Federation, India, China and South Africa in order to provide an effective response to, and support for, implementation of recommendations made by national health ministers. The South-East Asia and Western Pacific bi-regional Mekong network of Heads of WHO country offices held regular meetings, the last of which took place in Myanmar in February 2012, and was attended by representatives from Cambodia, China, Lao People's Democratic Republic, Thailand and Viet Nam. Country offices also played an active role in the United Nations Country Team. According to the Country Presence Survey Report 2012, WHO acted as chair or co-chair of the United Nations Country Team Health Thematic Group in 90% of the 116 countries, territories and areas. The same report also shows that about two thirds of United Nations Development Assistance Framework programme documents now include health as a specific outcome.

75. All four Organization-wide expected results are rated as "on track". Regular monitoring of the technical and financial situation at regional and budget centre level will ensure the optimal use of funds. Additional resources are being sought for the strategic objective mainly because of the additional cost of the numerous activities and intergovernmental processes associated with implementation of the reform agenda.

76. In 2013, more work will be required to monitor, manage and utilize the available resources. Through the full implementation of the recommendations of the Joint Inspection Unit, the necessary support will be provided for the country focus function. In order to ensure that the renewed corporate country cooperation strategies framework is fully implemented and applied, the regions will organize a systematic and timely review and renewal of their country cooperation strategies, and promote their utilization.

STRATEGIC OBJECTIVE 13: To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively

77. In 2012, work on the various elements of WHO reform, covering programming, human resources and financing, was scaled up to include proposals for future financing and a revised results-based management framework, which informed development of the draft twelfth general programme of work 2014–2019 and draft programme budget 2014–2015. Changes in the human resources policy were introduced to provide more flexibility in managing WHO's workforce.

78. The deadlines for statutory financial reporting were met and implementation of the International Public Sector Accounting Standards (IPSAS) was completed. Improvements were made to ensure the effectiveness of internal control measures governing activities associated with staff travel, finance and

procurement, and that staff members were aware of them. In this regard, communications and training on standard operating procedures and implementation of internal control measures will continue during 2013. The transfer of certain functions to the Global Service Centre in Kuala Lumpur has generated cost efficiencies in the Secretariat's administrative functions; additional activities, including procurement, pensions and awards processing, have been consolidated in the Global Service Centre. At headquarters, cost efficiencies have been achieved through increased attention to sourcing (for example, in security and building management) and management and administrative restructuring, and has also been carried out in the regions. In 2012, the technical upgrading of the Global Management System proceeded according to plan, allowing the implementation date of 1 May 2013 to remain. The Secretariat will then take steps to identify future opportunities for adapting the Global Management System to meet any new demands. A series of global information technology initiatives to reduce duplication and improve the security and productivity of the Organization and its staff are also being implemented, including global synergy (a standard managed workstation), unified communications, a single global e-mail system, a standard managed firewall solution for all offices and a centralized application inventory.

79. A growing number of emergency situations in countries during 2012, especially in the African Region and the Eastern Mediterranean Region, created operational challenges. Limited funding, reduced staffing levels and administrative weaknesses in some country offices also hampered work under this strategic objective.

80. Four of the six Organization-wide expected results are "on track" and two are "at risk". Organization-wide expected result indicator 13.2.2 (amount of voluntary contributions that are classified as fully and highly flexible) was rated "at risk" at the end of 2012. It is therefore essential that core voluntary contributions continue to be clearly recorded as such. Nevertheless, the economic downturn in several countries and the discussions on WHO reform, especially with regard to the future financing of WHO, have affected the total amount. The Secretariat will review the status of the core voluntary contributions account after the Sixty-sixth World Health Assembly. The Regional Office for the Eastern Mediterranean has expressed concern regarding the impact of limited resources and emergency situations on the information technology infrastructure in some countries in the Region. As a result, both Organization-wide expected result 13.2 (WHO resources management) and Organization-wide expected result 13.4 (information technology and systems for WHO) are rated as "at risk".

81. In 2013, the main focus will continue to be on initiatives associated with the managerial component of the WHO reform agenda, namely, results-based management and accountability; institutionalization of the enterprise risk management framework; financing of the Organization; and human resources policies and management. The Programme budget 2014–2015 will introduce a new results hierarchy. The financing dialogue with Members States and contributors, if approved by the World Health Assembly, will improve the management of funding gaps and ensure the alignment of resources with budgetary needs. In the human resources area, actions will focus on: increasing flexibility and mobility in the workforce; improving the WHO performance management framework; and enhancing staff development through a global online learning management system.

OVERVIEW OF BUDGET IMPLEMENTATION BY THE END OF 2012

82. In May 2011, the Sixty-fourth World Health Assembly approved a programme budget of US\$ 3959 million for 2012–2013, representing a reduction of some 13% from the level for 2010–2011.

83. The mid-term review confirms the realistic nature of the Programme budget 2012–2013, which was based on the income and expenditure projections for the financial period. Overall, the Programme budget 2012–2013 is expected to be fully financed, although funding across WHO continues to be

misaligned owing to the high level of earmarked financing. The Secretariat has introduced measures to reduce the misalignment over the remainder of the biennium, including establishment of the Resource Mobilization Task Force and the planned introduction of a resource management policy in 2013.

84. The Programme budget 2012–2013 is currently slightly under-implemented as a result of the continuation of the cost-saving measures that were introduced during the biennium 2010–2011 into the current biennium (including lower salary expenditure arising from a reduction in staff numbers and efficiency savings) and conservative spending by managers in the current financial climate. It is also customary for the implementation rate to accelerate during the second year of the biennium.

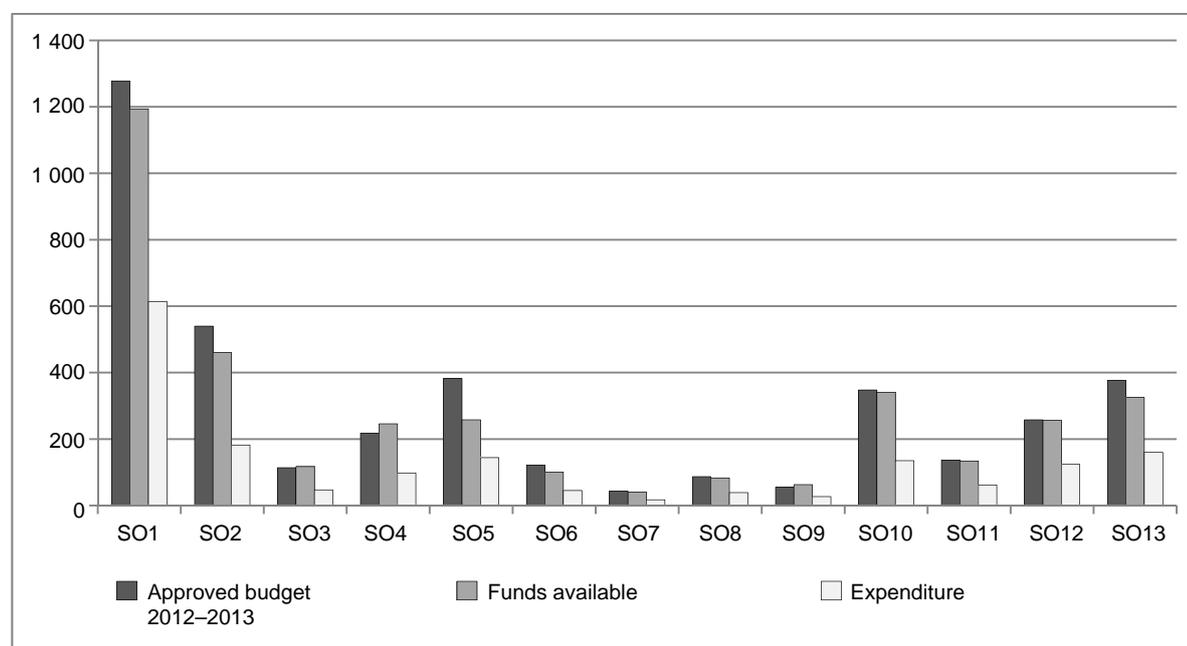
85. The following tables and figures show how the Programme budget 2012–2013 has been implemented up to 31 December 2012 by strategic objective, budget segment and major office.

**Table 2. Financial implementation by strategic objective
(US\$ million as at 31 December 2012)**

Strategic objective	Approved budget 2012–2013	Funds available			Funds available as % of approved budget	Expenditure	Expenditure as % of approved budget	Expenditure as % of funds available
		Assessed contributions	Voluntary contributions	Total				
SO1	1 278	74	1 120	1 194	93	614	48	51
SO2	540	41	419	460	85	182	34	39
SO3	114	43	74	117	103	47	42	40
SO4	218	53	193	246	113	98	45	40
SO5	382	16	242	258	68	144	38	56
SO6	122	34	67	101	83	45	37	44
SO7	43	20	21	41	96	17	39	41
SO8	87	30	53	83	95	39	45	47
SO9	55	21	42	63	114	27	49	43
SO10	348	139	202	341	98	135	39	40
SO11	137	29	105	134	98	62	45	46
SO12	258	198	58	256	99	124	48	49
SO13 ^a	377	201	124	325	86	160	42	49
Not yet distributed to strategic objectives		16	193	209				
Total	3 959	915	2 913	3 828	97	1 694	43	44

^a As well as the approved programme budget figure shown for strategic objective 13 in Table 2, an additional US\$ 138 million of related costs are financed through a separate cost-recovery mechanism under strategic objective 13*bis* (see Annex 1, Proposed programme budget 2012–2013, and further elaborated in the full document “Implementation of Programme budget 2012–2013, Mid-term review” (document HQ/PRP/13.1) in English only and available on request). These costs are included in Table 2 against all strategic objectives, which contribute to the financing through the post occupancy charge to recover costs of administrative services directly attributable to the work of these strategic objectives.

**Figure 1. Financial implementation by strategic objective
(US\$ million as at 31 December 2012)**



86. WHO's approved Programme budget 2012–2013 amounts to US\$ 3959 million. At the end of 2012, the available funds¹ distributed for implementation during the biennium amounted to US\$ 3828 million composed of funds carried forward from the financial period 2010–2011, assessed contributions and voluntary contributions. A total of US\$ 1694 million (43% of the approved budget) was implemented in 2012.²

87. Strategic objectives 2, 5 and 6 are not as well funded as some others, but funding for some strategic objectives exceeds the approved programme budget (strategic objectives 3, 4 and 9). In the case of strategic objective 3, this is explained by an increase in the funding received under noncommunicable diseases, which is a strategic priority for the Organization. Under strategic objective 4, additional funding for reproductive health and maternal health appears in the special programmes and collaborative arrangements segment. Under strategic objective 9, the available funding includes additional funding for the Codex Alimentarius Commission.

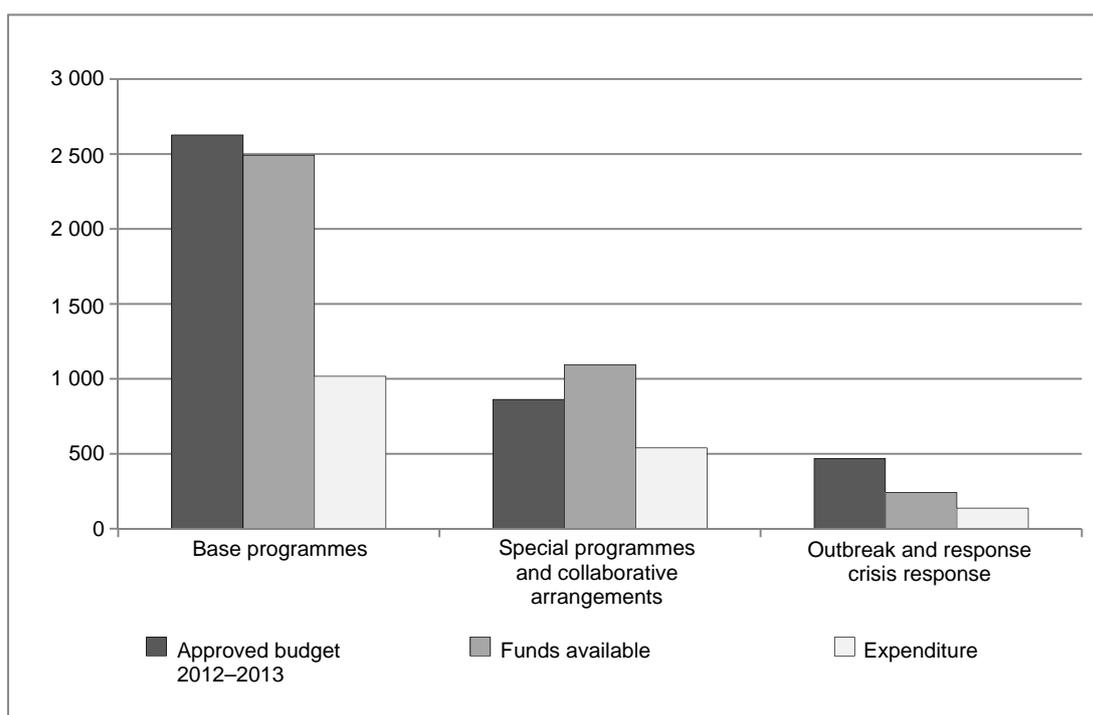
¹ Available funds include US\$ 915 million (24% of the available funds) from assessed contributions (excluding contingency withholdings for non-payment of assessments), US\$ 500 million (13% of available funds) from carry-forward from the financial period 2010–2011 and the balance which comes from voluntary contributions. They differ from operating revenue reported in the audited financial report 2012, which reflects only income recorded for 2012.

² Implementation: this figure represents expenditure relating to results in the Programme budget 2012–2013 only and does not include US\$ 125 million of expenditures incurred this financial period but relating to results in the Programme budget 2010–2011.

**Table 3. Financial implementation by budget segment
(US\$ million as at 31 December 2012)**

Segment	Approved budget 2012–2013	Funds available			Funds available as % of approved budget	Expenditure	Expenditure as % of approved budget	Expenditure as % of funds available
		Assessed contributions	Voluntary contributions	Total				
Base programmes	2 627	910	1 582	2 492	95	1 017	39	41
Special programmes and collaborative arrangements	863	4	1 090	1 094	126	539	62	49
Outbreak and response crisis response	469	1	241	242	51	138	29	57
Total	3 959	915	2 913	3 828	97	1 694	43	44

Figure 2. Financial implementation by budget segment (US\$ million as at 31 December 2012)



88. WHO's Programme budget 2012–2013 of US\$ 3 959 million consists of US\$ 2 627 million for base programmes (66% of the approved programme budget), US\$ 863 million for special programmes and collaborative arrangements (22% of the programme budget) and US\$ 469 million for outbreak and crisis response (12% of the programme budget).

89. The funds available¹ amount to: base programmes, US\$ 2492 million (95% of the programme budget for base programmes); special programmes and collaborative arrangements, US\$ 1094 million (126% of the programme budget for special programmes and collaborative arrangements); and outbreak and crisis response, US\$ 242 million (51% of the approved budget for outbreak and crisis response).

90. The base programme segment is currently facing a funding gap of US\$ 135 million against the approved programme budget. However, the level of funding for the special programmes and collaborative arrangements segment already exceeds the approved programme budget by US\$ 231 million as at 31 December 2012. The increase in funds available for the original budget for the special programmes and collaborative arrangements segment continues mainly to be related to work on poliomyelitis eradication.

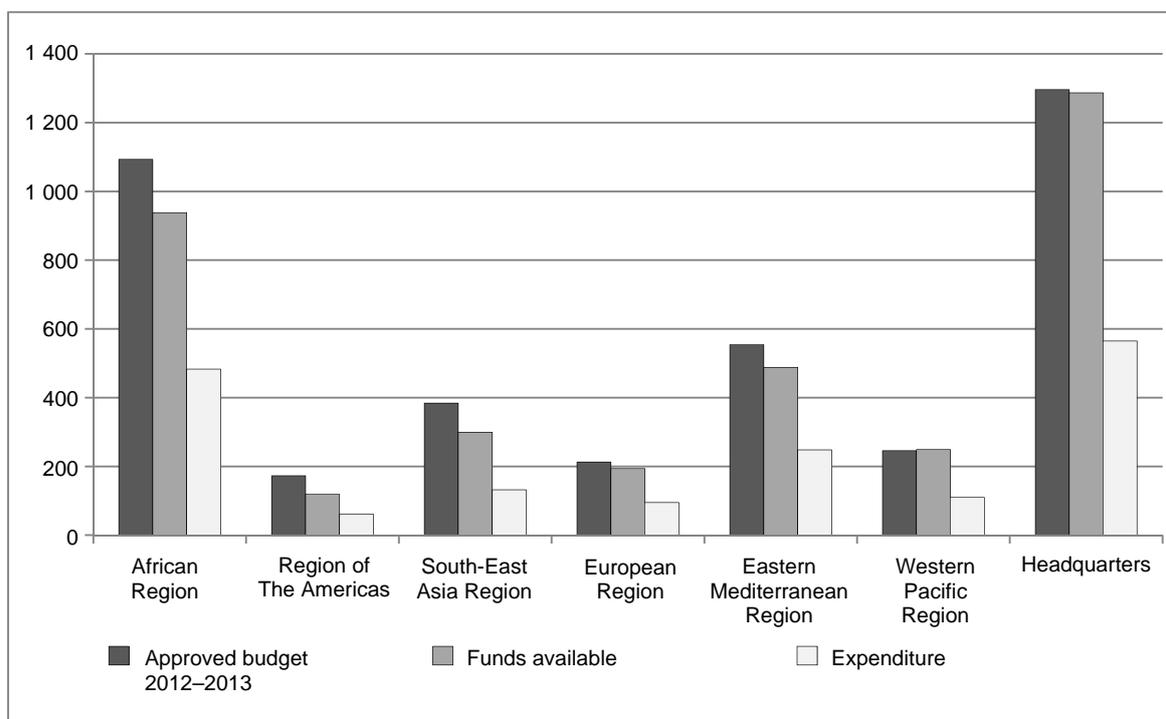
91. Activities under the outbreak and crisis response segment are governed by acute external events. The resource requirements are usually significant and difficult to predict making budgeting under this segment an uncertain process. The requirements for the biennium 2012–2013 have been estimated at US\$ 469 million. Current funding amounts to US\$ 242 million.

92. Expenditure is 39% of the approved programme budget for base programmes, 62% for special programmes and collaborative arrangements, and 29% for outbreak and crisis response.

**Table 4. Financial implementation by major office
(US\$ million as at 31 December 2012)**

Location	Approved budget 2012–2013	Funds available			Funds available as % of approved budget	Expenditure	Expenditure as % of approved budget	Expenditure as % of funds available
		Assessed contributions	Voluntary contributions	Total				
African Region	1 093	203	735	938	86	483	44	51
Region of the Americas	173	78	41	119	69	61	35	51
South-East Asia Region	384	97	202	299	78	132	34	44
European Region	213	57	137	194	91	95	45	49
Eastern Mediterranean Region	554	86	402	488	88	248	45	51
Western Pacific Region	246	74	175	249	101	110	45	44
Headquarters	1 296	304	983	1 287	99	565	44	44
Not yet distributed to major offices		16	238	254				
Total	3 959	915	2 913	3 828	97	1 694	43	44

¹ The division of resources available into WHO base programmes and other segments is based on management information and should be considered as a close approximation.

Figure 3. Financial implementation by region (US\$ million as at 31 December 2012)

93. In all offices, the funds available against the approved budget range between 69% for the Regional Office for the Americas and 101% for the Western Pacific Region and expenditures range between 44% and 51% of the available resources. The high availability of funds in a number of major offices is partly explained by the high proportion of funds for special programmes and collaborative arrangements, including poliomyelitis eradication, especially in the African Region and the Eastern Mediterranean Region. It also reflects a degree of success for the Organization's ongoing efforts to ensure more timely and needs-driven distribution of available resources in line with a more realistic Programme budget 2012-2013.

ACTION BY THE HEALTH ASSEMBLY

94. The Health Assembly is invited to note the report.

= = =