

## **Programme budget 2012–2013: performance assessment**

### **Summary report**

#### **FOREWORD BY THE DIRECTOR-GENERAL**

1. This document provides a systematic assessment of WHO's performance during the 2012–2013 biennium according to each of the Organization's 13 strategic objectives. The document is issued at a time of ongoing reforms at WHO and within a health development climate that places a premium on transparency, accountability and measurable results. In line with guidance from Member States, the Secretariat aimed to ensure that areas of WHO engagement are strategic and selective. During the biennium, the reform process shifted from a phase of policy analysis and problem solving to a more robust implementation phase. The two financing dialogues held in 2013 were a first for WHO and a clear expression of this shift.

2. Commitment to the health-related Millennium Development Goals continued to bring impressive results, again confirming the value of coordinating international health cooperation around a limited number of time-bound goals. For HIV/AIDS, new evidence that antiretroviral therapy prevents transmission of HIV sparked significant revision and consolidation of all related WHO policy advice, further simplifying treatment protocols and streamlining operational demands. On World Malaria Day 2012, WHO launched an initiative that consolidated WHO policy recommendations for testing, treating, and tracking every malaria case, stressing testing before treatment and tracking through a sensitive surveillance system. Countries that test before treatment, using simplified new diagnostic tests, reported declines in the prescribing of antimalarial medicines and in related costs. Surveillance, however, remains weak. Malaria trends could be established with certainty in only 58 out of 99 countries with ongoing malaria transmission. Prospects for attaining the goals set for tuberculosis increased, but WHO continued to track cases of multi-drug resistant and extensively drug-resistant tuberculosis and to warn the world accordingly.

3. Stimulated by the Every Woman, Every Child initiative, efforts to reduce maternal and child mortality accelerated. WHO supported these efforts through the coordination of large multicentre research studies and the provision of practical technical guidance. As just one example, WHO issued guidelines for an integrated approach to childhood diarrhoea and pneumonia that aims to eliminate the two diseases while also reducing the operational demands on health services. These efforts underscored the urgent need to develop systems of civil registration and vital statistics as fundamental to improved accountability and the measurement of results.

4. Countries continued to look to WHO for guidance in responding to the rise of noncommunicable diseases and the tremendous demands these diseases place on health systems, human resources, and budgets. A global action plan for the prevention and control of noncommunicable diseases was adopted by the Health Assembly in 2013. Within countries, the “best buys” identified by WHO allowed countries to move forward, regardless of resource constraints.

5. Some achievements during the biennium can be readily measured. With support from the GAVI Alliance, more countries introduced the newer vaccines into their routine immunization programmes. Especially good coverage with hepatitis B vaccine raised the exciting prospect of preventing a large proportion of liver cancer, one of the most common cancers in the developing world. The first-ever World Immunization Week, held in 2012, drew the participation of more than 180 countries. India remained polio-free. More than 150 diagnostics, medicines, vaccines, and active pharmaceutical ingredients were prequalified by WHO. In 2012 alone, well over 700 million preventive treatments were delivered to protect populations from the targeted neglected tropical diseases. Support for the WHO Framework Convention on Tobacco Control grew to 176 Parties; the Convention’s first protocol, aimed at eliminating illicit trade in tobacco products, was approved in 2012.

6. I was personally pleased to see the continuing impact of *The world health report* of 2010 on health systems financing.<sup>1</sup> More than 70 countries, at all levels of development, sought WHO technical assistance in moving their health systems towards universal health coverage. In providing this support, WHO was joined by the World Bank, adding weight to arguments that universal health coverage is economically desirable, feasible, and viable. Universal coverage is one of the most powerful social equalizers among all policy options. I am proud that, in this way, WHO is turning the principles of fairness and the right to health into tangible – and inclusive – benefits for people’s health.

## PERFORMANCE ASSESSMENT

7. The Programme budget 2012–2013 performance assessment is the final assessment carried out within the framework of the Medium-term strategic plan 2008–2013. This report provides an overview of the major achievements of expected results, and an overview of issues and lessons learnt from the work in countries and of the Secretariat. Budget implementation was also reviewed, allowing for programmatic and financial implementation to be considered simultaneously.<sup>2</sup>

8. The programme budget performance assessment is a self-assessment exercise that allows major offices to indicate whether their respective contributions to the expected results were partly, fully or not achieved. Progress ratings reflect the extent to which programmes have delivered on their expected outputs and 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.

## OVERVIEW OF ORGANIZATION-WIDE EXPECTED RESULTS

9. Table 1 shows the rating given for the achievement of the Organization-wide expected results by strategic objective.

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<sup>1</sup> The world health report: health systems financing: the path to universal coverage. Geneva: World Health Organization; 2010.

<sup>2</sup> See document A67/43, Financial report and audited financial statements for the year ended 31 December 2013.

10. Achievement of the Organization-wide expected results was assessed on the basis of the achievement of indicators, which were adjusted during the mid-term review to reflect the 2010–2011 actual achievements reported in the Programme budget 2010–2011 performance assessment. In some cases, the baselines and targets were also updated to reflect further clarification of the definitions and measurement criteria for individual indicators. The use of the indicator values as the primary method of assessing achievement of expected results at the end of the biennium is in accordance with the recommendations of the External Auditor. It also reflects the Organization-wide efforts to strengthen the culture of evaluation, as well as the specific capacity to assess results through the definition of, and reporting under, robust indicators.

11. Based on indicator achievement values, the Organization-wide expected results were assessed as follows:

- fully achieved – all indicator targets for the Organization-wide expected result were met or surpassed;
- partly achieved – one or more indicator targets for the Organization-wide expected result were not met; and
- not achieved – no indicator targets for the Organization-wide expected result were met.

12. Out of a total of 80 Organization-wide expected results for the biennium 2012–2013, 50 were assessed as “fully achieved” (63%) and 30 as “partly achieved” (37%), representing an improvement in performance over 2010–2011 when 46% of the Organization-wide expected results were rated as “partly achieved”.

13. Further analysis of the 30 “partly achieved” Organization-wide expected results shows that:

- a total of 12 out of 30 Organization-wide expected results were rated as “partly achieved” because either a more rigorous application of the indicator measurement criteria led to a reduction in the number of countries reported to have achieved the target, or countries lacked the capacity to provide timely reports on indicator achievement (for example, to complete reporting surveys or meet reporting deadlines);
- a total of four out of 30 Organization-wide expected results were rated as “partly achieved” because indicator targets in some Member States were not met as foreseen primarily as a result of ongoing political unrest (for example, in the Eastern Mediterranean Region); and
- the remaining 14 out of 30 Organization-wide expected results were rated as “partly achieved” because either one or more target Member States did not achieve the results expected, or Member States that had previously achieved the target failed to continue to meet the achievement criteria.

For each of the “partly achieved” Organization-wide expected results, further explanation has been included in the summary of each strategic objective in the main body of this report. More detailed information on the specific indicators that were not achieved can be found in the full document *Programme budget 2012–2013, Performance Assessment report*.<sup>1</sup>

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<sup>1</sup> Document HQ/PRP/14.1 produced in English only and available on request.

14. Improvements have been made to the review process, including the definition and monitoring of appropriate performance measures. However, 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 those matters have been discussed with Member States and have been addressed in the Programme budget 2014–2015 through a better delineation of Secretariat outputs and related indicators, and the monitoring and evaluation framework.

**Table 1. Progress rating by strategic objective**

	Strategic objective	Organization-wide expected results			
		Fully achieved	Partly achieved	Not achieved	Total
SO1	To reduce the health, social and economic burden of communicable diseases	2	7	0	9
SO2	To combat HIV/AIDS, tuberculosis and malaria	2	4	0	6
SO3	To prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment	2	4	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	7	1	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	5	0	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	6	0	0	6
SO10	To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research	9	4	0	13
SO11	To ensure improved access, quality and use of medical products and technologies	1	2	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 2006-2015	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	2	4	0	6
<b>Total</b>		<b>50</b>	<b>30</b>	<b>0</b>	<b>80</b>

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

15. More than 100 million individuals have received meningococcal A conjugate vaccine to date, resulting in a dramatic reduction of 94% in the disease incidence (tantamount to virtual elimination) in immunized populations. Progress was made in introducing new vaccines and promoting under-utilized vaccines. According to the latest available data,<sup>1</sup> during the reporting period *Haemophilus influenzae* type b (Hib) vaccine was introduced in 16 additional countries, pneumococcal vaccine in 33 additional countries, rotavirus vaccine in 13 additional countries and human papillomavirus vaccine in 12 additional countries. Four out of five children worldwide (83% of an estimated total of 111 million) received the recommended three doses of diphtheria-tetanus-pertussis vaccine during infancy in 2012, demonstrating sustained progress over a two-year period. By the end of 2012, global coverage with measles vaccine had reached 84%, with a 78% decline in estimated annual measles deaths and 13.8 million deaths averted between 2000 and 2012. In 2012, the first World Immunization Week took place and the Global Vaccine Action Plan 2011–2020 was endorsed. WHO has implemented an external quality assessment proficiency testing panel programme to monitor the performance of laboratories participating in the Global Rotavirus Laboratory Network and the Global Invasive Bacterial Vaccine Preventable Diseases Surveillance Network. Both the number of laboratories and the quality of the tests has increased.

16. In the three countries in which poliomyelitis remains endemic, national emergency action plans were revised and strengthened in 2013 to address the challenges of vaccinating every child against poliomyelitis. Oversight, accountability and programme management bodies reporting to heads of state were further extended from national to subnational level in order to intensify political and administrative accountability for the quality of key eradication activities. Three outbreaks in Cameroon, the Horn of Africa and the Middle East (with cases in the Syrian Arab Republic), served as a reminder of the risk of international spread from countries in which poliomyelitis is endemic. Outbreaks continue to be addressed swiftly, with coordinated multi-country responses and comprehensive phased outbreak plans. The Regional Committee for the Eastern Mediterranean, at its sixtieth session in October 2013, declared poliomyelitis transmission an emergency in all Member States of the Region.

17. An initiative was launched to accelerate progress towards goals for the eradication, elimination or control of 17 neglected tropical diseases that affect 1400 million of the world's poorest people. Key features of this initiative include a clear road map and negotiated substantial donations of 14 different medicines and therapies. Among WHO's other achievements were: publication of the second report on neglected tropical diseases, outlining the progress made since 2010;<sup>2</sup> its prequalification of diethylcarbamazine, the first medicine for treatment of a neglected tropical disease; introduction of a new first-line treatment for visceral leishmaniasis; and the scaling up of preventive chemotherapy against helminthiasis. In addition to the WHO Expert Consultation on Rabies, which re-evaluated the burden posed by, and methods of treating, rabies,<sup>3</sup> new strategies, diagnostic tools and treatment regimens for treating lymphatic filariasis were also published, as well as a new strategy for eliminating

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

<sup>2</sup> Sustaining the drive to overcome the global impact of neglected tropical diseases. Second WHO report on neglected tropical diseases. Geneva: World Health Organization; 2013. Document WHO/HTM/NTD/2013.1

<sup>3</sup> WHO Expert Consultation on Rabies: second report. Geneva: World Health Organization; 2013 (Technical Report Series, No. 982.).

human African trypanosomiasis. Five countries were certified to be free from dracunculiasis, making a total of 185 Member States that are free from the disease. Complementary diagnostic tools for yaws were developed and will be used for the eradication programme.

18. The *Global report for research on infectious diseases of poverty*<sup>1</sup> was launched at the conference on Innovation in Healthcare without borders organized by the European Commission. The report highlights reasons for carrying out research and outlines 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.

19. The Secretariat continued its efforts in support of countries, both in terms of technical cooperation and the provision of guidance and tools, towards their attainment of the minimum core capacities required by the International Health Regulations (2005) for detecting, preventing and responding to public health threats. Extensive guidance materials and training courses were produced and implemented in key areas, and were translated into other official languages of the Organization. Notwithstanding the progress made in countries, 119 Member States have requested a two-year extension to the June 2012 deadline.<sup>2</sup>

20. Work relating to specific diseases and conditions focused on influenza, dengue, Ebola virus disease, Middle East respiratory syndrome coronavirus (MERS-CoV) infections, yellow fever, chikungunya, nodding syndrome, viral hepatitis, cholera and meningitis. Technical support, including tools, guidelines and expert resources for investigation and control, was provided to countries that experienced outbreaks, with a total of 542 events managed between 1 January 2012 and 31 December 2013 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. WHO’s work on viral hepatitis advanced with the publication of a framework for global action on prevention and control and a report on the status of national hepatitis programmes in Member States.<sup>3</sup>

21. Integrated strategies, such as the Asia Pacific Strategy for Emerging Diseases and the Integrated Disease Surveillance and Response system, have enhanced Member States’ capacities to manage risks. The International Coordinating Group mechanisms against meningitis and yellow fever delivered 7 343 000 doses of yellow fever vaccine and 2 009 000 doses of meningitis vaccine in response to outbreaks in 2012 and 2013. The International Coordinating Group accepted to manage as well the international stockpile of oral cholera vaccine for emergencies, with 900 000 doses being available at the end of 2013. Under the Pandemic Influenza Preparedness (PIP) framework, WHO concluded three Standard Material Transfer Agreements-2 (SMTA2) with large vaccine manufacturers in order to secure real-time access to between 10% and 15% of pandemic influenza vaccine to be produced by those manufacturers at the time of the next pandemic. The Secretariat developed a process for quantifying the partnership contribution; and a plan for use of the received contributions was finalized in late 2013.

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<sup>1</sup> Global report for research on infectious diseases of poverty. Geneva: World Health Organization; 2012.

<sup>2</sup> See document A66/16.

<sup>3</sup> Prevention and control of viral hepatitis infection: framework for global action. Geneva: World Health Organization; 2012, and Global policy report on the prevention and control of viral hepatitis in WHO Member States. Geneva: World Health Organization; 2012, respectively.

22. WHO's work to combat the growing threat of antimicrobial resistance made advances, for instance by raising awareness through inclusion of the subject on governing bodies' agendas, and the convening of a Strategic and Technical Advisory Group to help to shape a global strategy and advise WHO on its coordination role. WHO also obtained valuable information from more than 100 Member States on current capacities and vulnerabilities in relation to antimicrobial resistance, which will be published in 2014.

23. Of the nine Organization-wide expected results under this strategic objective, two are rated as "fully achieved" and seven as "partly achieved". In the case of Organization-wide expected result 1.1 (access to vaccines), the "partly achieved" rating was due to the fact that 131 Member States instead of the target number of 135 achieved at least 90% of the three-dose diphtheria-tetanus-pertussis vaccination coverage (four countries missing the target by just 1%). In the case of Organization-wide expected result 1.2 (poliomyelitis eradication), the escalation of security threats created significant challenges in the implementation of programme strategies. As only 33 countries indicated their intention to stop using trivalent oral polio vaccine in routine immunization programmes, 28% instead of 75% of the Member States originally targeted met the criteria for the indicator. The rating for Organization-wide expected result 1.3 (access to interventions for neglected tropical diseases) reflects an increase in grade 2 disabilities in new cases of leprosy per million of the population at risk, a finding that is attributable to the use of innovative case-finding methods for accessing difficult-to-reach areas and population groups, as well as improved data management. The "partly achieved" rating for Organization-wide expected result 1.4 (surveillance and monitoring of all communicable diseases) was due to a change in the reporting date. Although only 154 of the 165 targeted Member States submitted their Joint Reporting Forms by the new deadline, the overall timeliness and completeness of the reporting improved significantly compared to previous years. Overall, 173 countries submitted their reporting forms within days of the deadline. Organization-wide expected result 1.6 (International Health Regulations (2005) core capacities) was undermined by the difficulty experienced by many countries in meeting the minimum core capacity requirements. Under Organization-wide expected result 1.7 (detection, assessment and response to epidemic and pandemic-prone diseases), the number of Member States that established preparedness plans and standard operating procedures fell short of the target. Organization-wide expected result 1.8 (response to epidemics and other public health emergencies of international concern) is rated as "partly achieved" because the target of 140 WHO locations proved to be very difficult to attain. The number of trained staff leaving the Organization or being transferred made it difficult to increase the number of offices with access to the global event management system, as a WHO location is only counted if it has at least one trained user.

24. In terms of lessons learnt, in the area of vaccines, WHO has provided high-level leadership, advocated for strong political and financial commitment and ensured effective collaboration with all stakeholders in order to sustain results and achieve the goals set out in the global vaccine action plan.<sup>1</sup> It will continue to identify and address constraints to safe immunization and service delivery in countries with low routine vaccination coverage rates, large numbers of un-immunized persons, and equity gaps.

25. Plans for ensuring the security of health workers are being developed for each reservoir of poliovirus. At the international level, WHO is deepening its engagement and seeking enhanced financial, technical and communications support from different Islamic institutions, both to inspire

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<sup>1</sup> See document A66/19.

greater confidence in Muslim communities and constituencies and increase community acceptance of the polio eradication programme.

26. The use of guides for strategic planning and budgeting facilitated the integration and coordination of interventions against neglected tropical diseases. Coordination with governments and other stakeholders improved throughout the biennium. Insecurity and war were major obstacles to the implementation of dracunculiasis eradication in Mali and South Sudan, as well as to delivery of preventive chemotherapy interventions.

27. The Secretariat continued to maintain its capacity to perform the functions entrusted to it under the International Health Regulations (2005). International and intersectoral coordination, transparency and information sharing have proved to be critical for risk assessment and response to epidemic and pandemic diseases, and this is increasingly recognized by Member States.

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

28. By the end of 2013, about 10 million people were receiving antiretroviral therapy in low- and middle-income countries, bringing within reach the global target of 15 million people on antiretroviral therapy by 2015. WHO supported expanding access to treatment and prevention by developing and disseminating new guidelines on the use of antiretroviral therapy, HIV testing and service delivery for vulnerable populations. Regional strategies and action plans on the same subjects were endorsed by the regional committees for the African, Eastern Mediterranean and European regions and supported by a regional task team in the Western Pacific Region and by regional guidelines on the health sector response to HIV in the South-East Asia Region. The number of new HIV infections is decreasing globally, but new infections are on the increase in the Eastern Mediterranean Region and in parts of the European Region. In both Regions, men who have sex with men, injecting drug users and sex workers are disproportionately affected.

29. The tuberculosis mortality rate has decreased by 45% since 1990, and 22 million lives have been saved since 1995 through the Stop TB Strategy. However, slow progress in controlling multidrug-resistant tuberculosis gives cause for concern, with only an estimated one in four cases being diagnosed and many patients not receiving treatment. During the biennium, as recommended by WHO, 98 Member States began to use a novel rapid molecular test, supplied at a concessionary price, to diagnose tuberculosis and multidrug-resistant tuberculosis. WHO issued interim guidance on use of the first novel anti-tuberculosis medicine to have become available in 40 years for treating multidrug-resistant tuberculosis. Countries in eastern Europe are implementing the consolidated action plan to prevent and combat multidrug-resistant and extensively drug-resistant tuberculosis in the European Region 2011–2015. Tuberculosis prevalence surveys supported by WHO in countries with a high disease burden have guided further action on case detection. A road map for childhood tuberculosis was launched with partners.<sup>1</sup> In the African Region, the joint response to HIV and tuberculosis coinfection, despite making progress, needs further strengthening to ensure full coverage with disease prevention tools and access to antiretroviral treatment for all those affected. A global strategy and targets for tuberculosis prevention, care and control after 2015 have been developed with Member States and partners and will be considered by the Sixty-seventh World Health Assembly.

30. Between 2000 and 2012, malaria mortality worldwide fell by 45% in all age groups, and by 51% in children under five years. If the rate of decrease is maintained, by 2015 deaths from malaria

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<sup>1</sup> Roadmap for childhood tuberculosis: towards zero deaths. Geneva: World Health Organization; 2013.



will have fallen by 56% across all ages and by 63% in children under five years. Three million (90%) of the 3.3 million deaths averted in children under five years of age are in sub-Saharan Africa and account for 20% of the 15 million child deaths averted in sub-Saharan Africa since 2000, which represents significant progress towards attainment of Millennium Development Goal target 4.A: reducing by two thirds, between 1990 and 2015, the under-five mortality rate. A total of 59 out of 103 countries with continuing malaria transmission in 2000 met the Millennium Development Goal target of reversing the incidence of malaria, and 52 are on track to reduce malaria incidence by 75% by 2015.

31. Several clinical studies were concluded, including: on the timing of antiretroviral therapy in tuberculosis and HIV coinfection in patients with high CD4<sup>+</sup> cell counts; the suitability of a novel therapeutic combination to shorten treatment; and the utility and policy relevance of the integrated community case management strategy.

32. Two of the six Organization-wide expected results are assessed as “fully achieved” and four, namely, 2.1 (prevention, treatment and care for HIV/AIDS, tuberculosis and malaria), 2.2 (gender-sensitive delivery of services for HIV/AIDS, tuberculosis and malaria), 2.3 (equitable access to essential medicines for HIV/AIDS, tuberculosis and malaria) and 2.4 (surveillance, evaluation and monitoring for HIV/AIDS, tuberculosis and malaria), were rated as “partly achieved”. Although progress was made in meeting all Organization-wide expected result indicators and most results were almost fully delivered, resource and capacity constraints in countries, including inadequate resources for the diagnosis and treatment of sexually transmitted infections, coupled with the aspirational level set for some indicators, explain why the targets were not fully met.

33. The key success factors in 2012–2013 centred on WHO’s leadership in normative areas, with the 2013 *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV*<sup>1</sup> and development of the draft post-2015 global tuberculosis strategy and targets as key outputs<sup>2</sup>. WHO also provided guidance and technical support for promoting equitable access to essential medicines, diagnostic tools and health technologies through its prequalification programme, and by supporting policy level discussions, including with middle-income countries, the Stop TB Partnership Global Drug Facility, the evaluation scheme for malaria rapid diagnostic tests, and PAHO’s Regional Revolving Fund for Strategic Public Health Supplies. Collaboration and coordination across the three levels of the Organization are strong, and have been a determining factor in the provision of technical support to Member States for securing grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria.

34. The main impediments encountered in less developed countries included low technical capacity and limited human resources for national programmes. Other limitations were imposed by the security situation in several countries in the African and Eastern Mediterranean regions and limited political support for actions to tackle HIV in parts of the Eastern Mediterranean and European regions. Lack of political support also adversely affects interventions targeting people in the European Region who inject drugs, impedes the effective control of tuberculosis, limits the attention directed towards key populations more generally, and jeopardizes the retention of malaria on the agenda in several countries.

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<sup>1</sup> 2013 Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV. Geneva: World Health Organization; 2013 (<http://www.who.int/hiv/pub/guidelines/arv2013/en/>, accessed 26 March 2014).

<sup>2</sup> See resolution EB134.R4.

35. The main challenge in tackling HIV/AIDS, tuberculosis and malaria is maintaining the momentum and progress made towards attaining the Millennium Development Goals, which requires continued WHO support and commitment by Member States. WHO will need to advocate increased investment by countries in their national responses to HIV/AIDS, tuberculosis and malaria from domestic sources and international funding.

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

36. The WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020 was endorsed by the Health Assembly in May 2013.<sup>1</sup> Global activities to strengthen policy coherence and collaboration in the prevention and control of noncommunicable diseases included the development of draft terms of reference for a global coordination mechanism and for the United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases. Regional and country workshops and training seminars were held in all WHO regions to provide technical support to Member States for developing and implementing multisectoral national policies and plans, scaling up national programmes and strengthening the political, financial and technical commitment of Member States to preventing and controlling noncommunicable diseases. Some countries have enhanced their surveillance of risk factors, expanded interventions to reduce exposure to them, and adopted a primary health-care approach to preventing and managing noncommunicable diseases.

37. The Mental Health Gap Action Programme is being extended 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 in adopting evidence-based policies, strategies and regulations in the area of mental health and substance abuse. Several documents were published, including *Dementia: a public health priority*.<sup>2</sup> That 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. It also describes the impact of dementia on individuals and society, as well as different national approaches to tackling dementia, considers issues associated with caregiving and caregivers, and discusses ways of increasing awareness and advocating for those with dementia. The Health Assembly adopted the comprehensive mental health action plan 2013–2020 in May 2013.<sup>3</sup>

38. The Regional Committee for the Western Pacific at its sixty-third session adopted resolution WPR/RC63.R3 on violence and injury prevention. Globally, progress was also made in improving road traffic safety, as evidenced by the increase in seat-belt and helmet use and decrease in drinking and driving and speeding in several countries. More than 100 countries participated in the Second United Nations Global Road Safety Week, generating action on pedestrian safety. WHO and the Government of Mexico hosted the world's leading violence prevention experts at the 6th Milestones of a Global Campaign for Violence Prevention Meeting. Several national and regional capacity-building workshops and training sessions were also conducted on trauma care, violence prevention and road traffic safety. During the Sixty-sixth World Health Assembly, WHO and the Governments of Brazil, Mozambique, Romania and Thailand launched the WHO Global Alliance for Care of the

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<sup>1</sup> Resolution WHA66.10.

<sup>2</sup> *Dementia: a public health priority*. Geneva: World Health Organization; 2012.

<sup>3</sup> Resolution WHA66.8.

Injured, a network of governmental and nongovernmental organizations working across the spectrum of pre-hospital and hospital care and rehabilitation to help victims of trauma.

39. In resolution WHA66.9 on disability the Health Assembly endorsed the recommendations of the *World report on disability*, and in September 2013 Heads of State and Government at the United Nations General Assembly High-level Meeting on Disability and Development committed themselves to ensuring that people with disabilities are able to contribute to their communities. WHO is expanding its efforts in line with the two initiatives and prepared a draft global disability action plan 2014–2021 that was noted by the Executive Board at its 134th session in January 2014.<sup>1</sup> A total of 60 countries have so far hosted policy discussions on the *World report on disability*.<sup>2</sup> The first World Congress on Community Based Rehabilitation (Agra, India, 26–28 November 2012) brought together 1500 experts and practitioners to share best practices and plan the next steps for work in the area. During the biennium, WHO published *International perspectives on spinal cord injury*,<sup>3</sup> as well as wheelchair service training packages.

40. “Towards universal eye health: a global action plan 2014–2019” was endorsed by the Health Assembly in resolution WHA66.4 in May 2013. A total of 74 Member States reported that they had implemented comprehensive national plans on eye and ear health. New WHO estimates were published, which showed that in 2010, 285 million people were estimated to have visual impairment, 39 million were blind and 246 had low vision, and 360 million people had disabling hearing loss. Several documents were issued, for example, on public-health management of chronic eye conditions, educational resources for eye care professionals, and promoting ear and hearing care through community-based rehabilitation. A total of 25 national child eye care centres received support and 10 were established. The WHO Alliance for the Global Elimination of Blinding Trachoma by the year 2020 met and the proceedings were published.

41. With support from the Secretariat, 21 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. Other activities are covered under strategic objective 6.

42. Of the six Organization-wide expected results, two were “fully achieved” and four “partly achieved.” Organization-wide expected results 3.1 (advocacy and support provided to increase political, financial and technical commitment), 3.2 (guidance and support on implementation of policies, strategies and regulations) and 3.3 (capacity to collect, analyse, disseminate and use data) were “partly achieved” owing to the lack of evidence for two mental health indicators, namely those on Member States with a mental health budget of more than 1% of the total health budget and the number of low- and middle-income Member States with basic mental health indicators annually reported. A systematic evaluation of these indicators using the *Mental Health Atlas 2011* was not possible. Adoption of the comprehensive mental health action plan 2013–2020 by the Health Assembly in resolution WHA66.8 has necessitated the inclusion of new indicators to replace the current ones which are now obsolete. Indicators on Member States with a unit in the ministry of health or equivalent national health authority, with dedicated staff and budget, for the prevention and control

<sup>1</sup> The draft action plan is submitted to the Sixty-seventh World Health Assembly in document A67/16.

<sup>2</sup> World report on disability 2011. Geneva: World Health Organization; 2011 ([http://www.who.int/disabilities/world\\_report/2011/report.pdf](http://www.who.int/disabilities/world_report/2011/report.pdf), accessed 27 March 2014).

<sup>3</sup> World Health Organization, The International Spinal Cord Society. *International perspectives on spinal cord injury*. Geneva: World Health Organization; 2013.

of chronic noncommunicable diseases and the number of Member States that have adopted a multisectoral national policy on chronic noncommunicable diseases were not fully achieved owing to a lack of high-level commitment, shortage of resources and competing priorities, including the urgent need to prioritize other activities in a number of countries. Organization-wide expected result 3.5 (multisectoral, population-wide programmes) was not fully achieved because of the partial achievement of the indicator on the number of Member States implementing strategies recommended by WHO for the prevention of hearing or visual impairment. Limited resources dedicated to eye and ear care service provision at country level prevented full achievement.

43. WHO's advocacy has had an impact on advancing the global agendas on noncommunicable diseases, injuries and violence, mental health, disabilities and blindness and deafness. The road maps provided by the global action plans in these areas will help to shift the focus of action from advocacy and normative guidance to implementation and impact monitoring. Although human and financial resources remain insufficient at national and global levels for tackling the large agenda and challenges, efforts will continue to gradually increase the available resources in order to ensure national and local action.

**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**

44. Under the umbrella of the United Nations Secretary-General's Global Strategy for Women's and Children's Health, the momentum and political commitment have been sustained towards achieving Millennium Development Goals 4 (Reduce child mortality) and 5 (Improve maternal health). Although progress has been made over past decades – the global maternal mortality ratio decreased by 47% between 1990 and 2010 and the under-five mortality rate fell by 47% between 1990 and 2012 – it has not been sufficient. In 2012, of the 6.6 million children who died before their fifth birthday, nearly three million were newborns in their first month of life. A total of 287 000 women died as a result of complications during pregnancy and childbirth, and the 2.6 million stillbirths that occur annually remain a silent tragedy.

45. By the end of 2013, a total of 100 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. In addition, 73 countries now have a policy on universal access to sexual and reproductive health.

46. Capacity-building workshops on, inter alia, maternal death surveillance and response were conducted in all 75 countries that account for 95% of maternal and child deaths 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 and on whose coordinating committee WHO serves, published its 2013 update report.<sup>1</sup> Countries in all regions were supported in revising or updating their road maps and plans for accelerating a reduction in maternal, newborn and child mortality, and to build capacity in strategic planning, including cost and impact analysis. Progress was made in building the capacity of national experts in operational research. Guidelines on improving the quality of care of

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<sup>1</sup> Accountability for maternal, newborn and child survival: the 2013 update. Geneva: World Health Organization; 2013.

mothers, newborns and children have been prepared or updated and disseminated in countries. Normative guidelines were published, including the health-care response to intimate partner and sexual violence, optimizing the health work force for the achievement of Millennium Development Goals 4 and 5, and cervical cancer prevention and control.

47. Under the UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction, capacity to develop and implement research in sexual and reproductive health was strengthened in a total of 29 institutions in Member States in all regions.

48. During the biennium, 69 countries achieved the goal of having a functioning active healthy ageing programme consistent with resolution WHA58.16 on strengthening active and healthy ageing. The Global Network of Age-friendly cities and communities expanded to include more than 150 cities and communities in 21 countries, as well as 10 affiliated country programmes.

49. Seven of the eight Organization-wide expected results are rated as “fully achieved” and one as “partly achieved”. Organization-wide expected result 4.1 (scaling up of universal access to health interventions) was only “partly achieved” owing to the partial achievement of the indicator on the number of Member States that have developed, with WHO support, a policy on achieving universal access to sexual and reproductive health because of financial constraints and inadequate human resources to support implementation.

50. In order to make progress towards achievement of Millennium Development Goals 4 and 5 by the 2015 deadline and beyond, WHO will need to intensify its work, including cooperation with partners, such as the H4+ partnership (UNAIDS, UNFPA, UNICEF, UN Women and the World Bank). Many initiatives have recently been launched in the area of reproductive, maternal, newborn, child and adolescent health and there is a need for continued coordination among partners for implementing and monitoring those initiatives. In this regard, the strengthening of technical capacity and human resources in WHO country offices is essential. There is a need for further resource mobilization, in particular to ensure sufficient investment in reproductive, maternal, newborn, child and adolescent health at country level. The engagement of other sectors is also vital. Global attention is increasingly being focused on population ageing and health. However, there is an urgent need for a platform that brings together key experts to advise decision-makers on global action priorities and up-to-date guidance and coordinate global responses on ageing and health.

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

51. In order to reduce morbidity, mortality and disability resulting from emergencies, Member States and the Secretariat made progress in building their preparedness and response capacities, and in coordinating health-sector response and recovery services in humanitarian emergencies.

52. Member States across all regions developed and implemented disaster and emergency risk management programmes, which included building more resilient health facilities, strengthening national emergency response capacities, and forging stronger strategic partnerships at global, national and subregional levels both within the health sector and beyond. During the biennium, 40% of Member States completed a health risk assessment and took steps to make hospitals safer, and 31% conducted an emergency simulation exercise. Member States that are strengthening their emergency risk management programmes are reaping the benefits, as witnessed in the response to typhoon Haiyan in the Philippines thanks to national preparedness, including the application of national evacuation

protocols, national medical response teams, health cluster leadership, involvement in international protocols for foreign medical teams, and national disease surveillance systems.

53. The Secretariat provided policy options and promoted best practices for making hospitals safer, strengthening emergency preparedness capacities (for the Olympic Games in London in 2012, for instance), improving emergency risk management in urban settings, taking into consideration such specifics as concentrated infrastructure and population, and establishing emergency operations centres in numerous countries, including the Lao People's Democratic Republic and Mongolia. WHO also provided related training materials, guidance and tools. At the global level, progress was made in developing a policy framework for emergency health risk management, as well as a capacity survey tool and a safe hospitals index. WHO continued to promote health as a central component in regional and global multisectoral discussions and documents on emergency risk management.

54. The Secretariat reformed its institutional readiness programme in order to enhance its support to Member States during an emergency response. Measures included: establishing a Global Emergency Management Team to lead and monitor WHO's emergency work; conducting Organization-wide emergency simulation exercises; developing 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 creating and testing a mechanism for rapidly deploying emergency experts. WHO produced and promoted technical guidance and tools to improve the quality of health interventions during an emergency response to a chemical or radionuclear health event or a communicable disease outbreak; additional guidance and tools relating to mental health, reproductive health, water and sanitation, and nutrition in emergency settings were developed.

55. The ongoing improvements in the Secretariat's work in humanitarian emergencies have contributed to its enhanced performance at country level in support of Member States through better leadership and coordination of the health cluster and the health sector, leading needs assessments and strategic planning, producing information bulletins, promoting social communications, strengthening surveillance and early warning systems, and promoting quality interventions based on best practice. WHO is building its capacity to fulfil its obligations as health cluster lead agency with the aim of serving, where necessary, as provider of last resort of health services to affected populations, for example, by running mobile clinics in the Syrian Arab Republic or conducting vaccination campaigns in the Central African Republic.

56. Of the 29 acute emergencies (so graded by the Secretariat according to its Emergency Response Framework) during the biennium, the most challenging were those in the Central African Republic, Mali and the Syrian Arab Republic. The crisis in the Syrian Arab Republic triggered Organization-wide support through WHO country offices in Egypt, Iraq, Jordan, Lebanon, Syrian Arab Republic and Turkey, and in the country application of the Emergency Response Framework resulted in more predictable and effective WHO action in areas such as rapid assessment, coordination, reporting, disease surveillance and response, and regular updating of health action plans. In Mali, WHO led an exercise to assess and map health resources, which has been central to the development of a government-led transition plan for the health sector. In the Central African Republic, WHO worked with the Ministry of Health on a rapid assessment of services, and assisted with their delivery where feasible in the prevailing context.

57. Progress was made in all regions towards achieving Organization-wide expected result 5.1 (strengthening national emergency risk management and WHO's readiness), but the overall rating of "partly achieved" owed to the fact that the indicator targets were ambitious, the Organizational shift required to meet them, incomplete normative work and a lack of staff and resources. The Secretariat made substantial progress in the area of Organizational readiness. The enormity of the effort required

by WHO to respond to emergencies throughout the biennium, including three large and complex emergencies (classified by WHO as Grade 3), constrained the time and human resources available for work on Organization-wide expected result 5.1. The fact that limited resources were allocated to the work at national, international and headquarters levels was a contributing factor.

58. Organization-wide expected result 5.7 (emergency response operations) is also rated as “partly achieved”. Even though good progress was made in institutionalizing, applying and monitoring WHO’s performance as specified in the Emergency Response Framework, a consistently high standard of performance has not yet been achieved in its response to large-scale emergencies. This was evident in its inadequate response to the public health consequences of the drought in the Sahel region of Africa and the civil unrest in Myanmar. In 2013, WHO’s response in the Central African Republic, the Philippines, South Sudan and the Syrian Arab Republic demonstrated a step change in its emergency response work. Constraints on optimum performance included, insecurity, shortages of health personnel and supplies, rising costs, difficulties associated with transport, and insufficient funding, particularly in the Central African Republic. In addition, the indicator target is demanding and ambitious, and WHO lacked the required core human and financial resources to be appropriately agile, rapid and ready.

59. Throughout the biennium, actions taken have proved beneficial and key lessons have been learnt that will be applied in 2014–2015. WHO’s role in advocating for and promoting health in the context of the emergency risk management agenda has been successful. Member States need a policy framework, related guidance and tools in order to translate emergency risk management concepts into action. WHO’s emergency reforms have been extremely constructive and need to be further strengthened and institutionalized. Its Global Emergency Management Team has played a crucial role in standardizing the Organization’s emergency work and in applying and tracking performance against the standards of the Emergency Response Framework and associated standard operating procedures. However, there is sometimes a failure to ensure that the skills of staff match the situation to which they are assigned, as well as to invest in staff development, including project design, management and reporting. WHO needs to provide stronger leadership to the Global Health Cluster and more consistent support to country health clusters. In that regard, steps have already been taken to apply the lessons learnt, for instance through the establishment of a Global Health Cluster unit with the task of promoting standard operating procedures to track performance more systematically, and designing a staff development plan.

**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**

60. In May 2013, the Health Assembly adopted a global monitoring framework for the prevention and control of noncommunicable diseases, including a set of key indicators and challenging voluntary global targets. Cardiovascular diseases, cancers, diabetes and chronic respiratory diseases, although not accounting for all noncommunicable diseases, are the currently agreed common focus of Member States. Such diseases account for about two thirds of all cases of morbidity, disability and handicap, as well as of deaths globally. They share four major behavioural risk factors, namely, tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity, as well as biomedical factors such as raised blood pressure, blood glucose and lipid concentrations, and overweight and obesity. Recognizing the complex and formidable cultural, economic, political and social forces that combine to influence the risk factors, Member States have charged the Secretariat, as well as health ministries, to reduce those risk factors, not only within traditional health sectors, but across all government sectors and with private industry and civil society. In the biennium 2012–2013, WHO took steps to

engage several organizations of the United Nations system and their natural constituencies in the work to prevent and control selected noncommunicable diseases.

61. The global monitoring framework for noncommunicable diseases has provided WHO with a structure for improving its capacity-building efforts in order to support countries not only in monitoring, the magnitude of the priority diseases and their risk factors but in monitoring and evaluating the progress made in implementing selected measures to stem the epidemic of those diseases. During the biennium, WHO assisted in the conduct of 19 STEPwise adult risk factor surveys and 13 global school-based student health surveys.

62. In recognition of the value of working across government, high-level government officials and experts from 122 Member States, organizations in the United Nations system and the Secretariat, as well as academics and civil society representatives, at the 8th Global Conference on Health Promotion (Helsinki, 10–14 June 2013) endorsed the Helsinki Statement on Health in All Policies. The Conference has led to the publication of numerous technical papers, including the draft Health in All Policies Framework for Country Action.<sup>1</sup> The WHO Centre for Health Development in Kobe, Japan, has provided substantial support to 40 countries for implementing the Urban Health Equity Assessment and Response Tool (Urban HEART). WHO has also produced country best practice examples to support Member States, especially those that have yet to act, explore ways of implementing Health in All Policies.

63. Given the global community's commitment to implementation of the WHO Framework Convention on Tobacco Control, the Secretariat supported Member States in conducting 32 Global Youth Tobacco Surveys and nine Global Adult Tobacco Surveys. Guidelines on the management of tobacco use and exposure to second-hand smoke in pregnancy were published. WHO coordinated the monitoring of implementation of selected tobacco demand-reduction measures. During the biennium, implementation at country level of the provisions of the Framework Convention increased substantially as a result of the Secretariat's cooperation with Member States. More than 2300 million people are now protected by at least one of the most cost-effective demand-reduction measures. Australia was the first country to introduce plain packaging. The overall impact has provoked further aggression on the part of the tobacco industry in the form of trade and investment mechanisms. In response, the Secretariat has provided technical advice to Member States for designing national plans to counter the industry's interference and to strengthen their ability to deal with trade and investment issues related to tobacco control.

64. With regard to the global strategy to reduce the harmful use of alcohol and relevant regional strategies and action plans, at least 90 Member States have developed, revised or are in the process of formulating national policies. The Secretariat, in collaboration with Member States, conducted the global survey on alcohol and health in 178 countries, covering 98% of the world's population, to collect information on alcohol consumption, alcohol-related harm and policy responses. The findings were used in regional capacity-building workshops and network meetings on alcohol policy development and implementation that were organized for government officials from more than 100 countries. These workshops and meetings have strengthened the capacity of governments in initiating, revising and more effectively implementing alcohol policies and strategies in countries. In collaboration with the United Nations Office on Drugs and Crime, WHO provided technical support for drug dependence treatment and care to 64 countries, with the aim of reducing the public health burden associated with alcohol and drug use. Guidelines on the identification and management of

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<sup>1</sup> [http://www.who.int/healthpromotion/conferences/8gchp/130509\\_hiap\\_framework\\_for\\_country\\_action\\_draft.pdf](http://www.who.int/healthpromotion/conferences/8gchp/130509_hiap_framework_for_country_action_draft.pdf), accessed 27 March 2014.



substance use and substance-use disorders in pregnancy have been developed. Two global information systems and their regional versions on alcohol and health, and resources for the prevention and treatment of substance-use disorders were further developed, updated and integrated into the Global Health Observatory.

65. During the biennium, advances were made in the areas of prevention of childhood obesity, reduction of salt/sodium intake in populations, 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 foods to children and promoting physical activity.

66. Multisectoral capacity-building workshops for population-based prevention of childhood obesity were held in 17 countries. Technical assistance was provided to Fiji, Hungary and Mexico in connection with fiscal measures to reduce consumption of foods with a high content of total fat, sugar and salt, and to Malta for promoting physical activity. The European Network on reducing marketing pressure on children has continued to work with the Secretariat to support Member States in implementing the recommendations on marketing of foods and non-alcoholic beverages to children, and several Member States in the European Region have introduced regulations to limit the marketing of foods high in fat, sugar and salt aimed at children. Technical assistance was provided for strategies to reduce salt intake in populations, including the setting of targets for industry reformulations. Several Latin American countries have also used the WHO toolkit process to develop their national strategies to reduce salt intake. The Secretariat has issued the tools for prioritizing population-based prevention of childhood obesity in French and Russian as well as English. A technical expert group meeting on salt reduction and iodine fortification strategies in public health was convened by WHO to demonstrate that the two strategies can co-exist and their individual actions be synergized.

67. Capacity was built at regional and country levels in all WHO regions through workshops in which representatives of relevant ministries, such as agriculture, sport and recreation and education, participated. The Health Assembly's endorsement of the voluntary global targets for obesity, physical inactivity and sodium/salt reduction<sup>1</sup> will serve to strengthen the advocacy efforts of health ministries to raise awareness of such risk factors.

68. The capacity of countries to use data-collection tools and systems, as well as data on sexual behaviour, was strengthened. WHO worked with partners in support of the London Summit on Family Planning, held in 2012 in order to meet the contraceptive needs of countries with the highest gaps and promote safer sexual behaviour. The Secretariat supported five countries in the African Region to strengthen their health information systems in connection with measuring core indicators of reproductive and sexual health and behaviour. It also supported enhanced sexuality education programmes in the European Region, and the integration of sexual health education in adolescent health programmes in the South-East Asia Region.

69. Overall, four of the six Organization-wide expected results were rated as "fully achieved" and two, namely, "national systems for surveillance of major risk factors" and "unhealthy diets and physical inactivity", as "partly achieved". Although youth surveys for the former expected result were on track, adult survey numbers were slightly lower than expected. Despite an improvement on the baseline, the cost and complexity of completing national adult surveys meant earlier expectations were not met. Some progress was made towards achieving the second partly-achieved expected result, but

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<sup>1</sup> Resolution WHA66.10, Annex, Appendix 2.

certain regions continue to report a lack of political commitment, as well as of human and financial resources.

70. Working across sectors and countries was difficult in terms of the time needed for communication and coordination among the different partners, and limited capacity, particularly where strong leadership was lacking. Some regions managed to overcome such obstacles through continued capacity-building activities, acknowledgement of cross-sectoral and cross-unit difficulties, and regular regional consultations and stakeholder communication. Providing evidence and examples of positive policy changes also served to strengthen collaborative efforts. Some regions used novel approaches, such as distance coaching and professional simultaneous translation, to overcome geographical and language barriers in workshops.

71. Globally agreed noncommunicable disease targets and indicators and a global monitoring framework are helping to stimulate action at country level, and improved responsiveness and prioritization are contributing towards strengthening surveillance of noncommunicable disease risk factors. The availability of well-developed tools and methods, which can be easily adapted to country contexts, such as STEPS and global school-based student health surveys, strengthen implementation of risk factor surveillance at country level. Actions taken to overcome obstacles, such as political instability in countries, limited resources and capacity and competing priorities, included: regional workshops on planning surveys and analysing data; harnessing collaborating centre support; highlighting the importance of risk factor surveillance through regional and country level meetings; and continuous and direct contact with country-based staff.

**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**

72. The World Conference on Social Determinants of Health in October 2011 and the Health Assembly's subsequent adoption in May 2012 of resolution WHA65.8 endorsing its outcome, namely 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. Analysis by the Secretariat in March 2013 showed that 105 country cooperation strategies include requests for technical support for addressing social determinants of health or implementing a "health-in-all-policies" approach.

73. The Regional Committee for Europe at its Sixty-second session adopted Health 2020, the European policy framework supporting action across governments and society for health and well-being. The objectives of Health 2020 have been integrated into all European Region programmes and country support is being provided through the framework. After consultations in other regions, the regional framework on Health in All Policies in the South-East Asia Region and the Position Statement on Health in All Policies in the African Region were endorsed by the respective regional directors. The African regional report on implementing health in all policies is based on studies conducted in 21 countries in the African Region. In collaboration with the WHO Centre for Health and Development in Kobe, Japan, the regional offices scaled up the mainstreaming of social determinants of health and health equity issues in urban areas using the Urban Health Equity Assessment and Response Tool (Urban HEART).<sup>1</sup> In the Region of the Americas, the Faces, Voices and Places

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<sup>1</sup> In Fiji, India, Indonesia, Ireland, Jordan, Lebanon, Nepal, Sri Lanka, Thailand, Turkey and United Arab Emirates.

initiative was introduced in 18 countries where networks of municipalities continue to work with the most vulnerable communities.

74. In the area of ethics, the standards for research ethics systems and guidance for use of placebos in vaccine trials were developed. The EU Clinical Trials Register, recognized as the primary WHO registry, was expanded, and WHO's International Clinical Trials Registry Platform database now contains information on more than 220 000 trials. In 2012, representatives of 38 national ethics committees participated in the 9th Global Summit of National Ethics Committees (Carthage, Tunisia, 26 and 27 September 2012), which discussed issues including advanced research, bio-banking and organ, tissue and cell transplantation. Delegates from national tuberculosis programmes from more than 15 Member States have benefited from training workshops on incorporating ethics and human rights values and principles into the management of tuberculosis and multidrug-resistant tuberculosis. The secretariat of the WHO Research Ethics Review Committee supported the review and approval of more than 200 research projects that were carried out with technical and/or financial support from WHO.

75. The Secretariat's efforts also focused on mainstreaming gender, equity and human rights concerns in all decision-making processes across the three levels of the Organization. A draft six-year strategy document was developed, with an institutional accountability mechanism to guide the way forward and measure progress.

76. All five Organization-wide expected results were achieved as a result of the increased political priority accorded by Member States to addressing social and economic determinants of health, joint action across the Organization on mainstreaming gender, equity and human rights, and strategic initiatives across many regions to support Member States in developing a comprehensive response.

77. Key factors for success at country level include: generating political commitment through advocacy; sharing experiences among countries; providing support to Member States to develop national plans of action on social determinants of health; evidence-building around health inequities and response; strengthening the linkages between health systems and social determinants of health; and involving priority health programmes on social determinants of health. An overarching policy framework and strategy provide the impetus for change by according legitimacy to, and focusing on, values and approaches that work.

78. Progress made in both the Secretariat and Member States in mainstreaming gender, equity and human rights required commitment at the highest level, clear guidance and an accountability mechanism. The Secretariat has worked on all three elements in a phased adaptive approach, starting with two countries before expanding the number in the next biennium.

**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**

79. The strategic objective covers global and regional efforts to tackle environmental and occupational determinants of health that are responsible for one quarter of the global burden of disease. Provision of safe drinking water, sanitation and hygiene services remains a major challenge in most regions. New evidence released in 2012 revealed that air pollution is now a leading

environmental risk factor causing nearly 7 million premature deaths each year.<sup>1</sup> Additional environmental and occupational health challenges include sound management of chemicals, health in the workplace, climate change, and in some cases, radiation.

80. Guidelines have been drawn up on the economic evaluation of water and sanitation interventions covering: water safety planning for small community supplies; rapid assessment of drinking water quality; monitoring and evaluating household water treatment and safe storage initiatives; and managing health care waste. Guidelines on indoor air quality and household fuel combustion were developed and implementation of recommendations was piloted at country level.

81. Major assessments of drinking water quality concerned pharmaceuticals and other chemicals. In the area of chemical safety, an updated risk assessment of insecticides for aircraft disinsection and a risk assessment of chromium(VI), a chemical of public health concern, were published. A health risk assessment was conducted in 2013 as a follow-up to the Fukushima nuclear accident, based on a preliminary radiation dose estimate that was developed in 2012. New data and models to estimate the burden of disease associated with indoor air pollution were published and used for the global estimates of burden of disease. They identified air pollution as one of the most significant public health issues of our time. A new analysis revealed a large gap in access to energy in health-care facilities in developing countries,<sup>2</sup> which led to inclusion of this issue in global energy debates.

82. WHO continued to support country initiatives on environmental and occupational health in various settings, such as homes, cities, schools, health-care settings and workplaces. The workplace was one setting where the progress made in implementation of resolution WHA60.26 on workers' health: global plan of action was documented.<sup>3</sup>

83. Activities aimed at strengthening environmental and occupational health risk management systems and strategies focused on enhancing the capacities of national and regional poison centres, and explored options for expanding delivery of occupational health services through primary health care. Water safety planning and related capacity-building activities were supported in more than 16 Member States across all WHO regions. To enhance global efforts in chemical risk assessment, a new network of institutions was launched in 2013. Intersectoral action on environmental determinants of health increased globally, regionally and in countries, particularly in the areas of workers' health (where attention was focused on the elimination of asbestos-related diseases) and safe management of chemicals, and in specific sectors, for example, transport, energy and the extractive industries. A significant part of WHO's support was directed towards building the capacity of Member States in using health impact assessments, a key instrument for health-in-all policies.

84. Regional governance in environmental and occupational health was enhanced through, *inter alia*, the European Environment and Health Task Force and the European Environment and Health Ministerial Board established in the wake of the Parma Declaration on Environment and Health, the Health and Environment Strategic Alliance established in the context of the Libreville Declaration on Health and Environment in Africa, and as a result of various activities supported by technical working groups working with the regional forums on environment and health in the

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<sup>1</sup> About 3.5 million of the deaths are attributed to exposure to indoor air pollution and 3.2 million to outdoor air pollution.

<sup>2</sup> Adair-Rohani H, Zukora K, Bonjour S, Wilburn S, Kuesel AC, Hebert R et al. Limited electricity access in health facilities of sub-Saharan Africa: a systematic review of data on electricity access, sources, and reliability. *Glob Health Sci Pract* 2013;1(2):249-261. (<http://dx.doi.org/10.9745/GHSP-D-13-00037>, accessed 27 March 2014).

<sup>3</sup> See document A66/27 section J.

Western Pacific and South-East Asia regions. A new joint ministerial forum on health and the environment was also established in the Eastern Mediterranean Region.

85. WHO underlined the place of health on the post-2015 development agenda by providing examples of health indicators used to track achievements in energy, cities, water, agriculture, jobs and disaster preparedness, under consideration by Member States.<sup>1</sup> As a result of this work and the Health Assembly's endorsement of the need to integrate health both as a target and prerequisite of sustainable development,<sup>2</sup> health issues featured prominently in the global discourse on sustainable development, inter alia in the United Nations Conference on Sustainable Development (Rio+20) in 2012 and the outcome document, *The future we want*.

86. WHO asserted its leadership in several major international partnerships for sustainable development, including the United Nations Secretary General's Sustainable Energy for All initiative (which now includes targets for access to clean energy in the home and health-care facilities), the Climate and Clean Air Coalition, the Global Alliance for Clean Cookstoves, and the WHO-UNEP Global Alliance to Eliminate Lead Paint. WHO also continued to ensure adequate representation of health issues in multilateral environmental agreements and international chemicals conventions, providing for instance support for the health sector engagement strategy for the Strategic Approach to International Chemicals Management (adopted in 2012) and in the context of the Minamata Convention on Mercury (which was adopted at a Conference on Plenipotentiaries in October 2013).<sup>3</sup>

87. Technical support was provided to 124 Member States to prepare plans for adapting health systems to climate change, and to 22 for implementation of large-scale adaptation projects. The Secretariat has contributed to partnerships with UNEP, WMO, UNDP and the United Nations Institute for Training and Research by promoting the health benefits of actions to reduce climate pollutants, the application of climate information in the interests of health, and programming for adaptation to climate change, and by representing the health element in climate negotiations. It has issued major reports on mapping climate and health linkages, assessing health vulnerability and adaptation options, the economic and gender dimensions of health adaptation, and including health in negotiations on climate change, biodiversity loss and desertification.

88. All six Organization-wide expected results and all the indicators for the biennium 2012–2013 were “fully achieved”. In the case of country indicator targets, the result was due to the alignment of work streams to facilitate delivery of multiple project objectives under fewer projects, and leveraging direct support from the regional offices, headquarters and partners, such as WHO collaborating centres, in order to implement country activities.

89. Work on environmental and occupational determinants of health in specific sectors, such as energy, water and the extractive industries, provided useful insights into how to operationalize a health-in-all-policies approach. For example, the importance of engagement in intergovernmental processes, such as the regional forums on environment and health in which decision makers from different sectors are represented, cannot be overemphasized. It is often during such processes that

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<sup>1</sup> Measuring health gains from sustainable development. Geneva: World Health Organization; 2012.

<sup>2</sup> Resolution WHA66.11 on health in the post-2015 development agenda.

<sup>3</sup> At its 134th session, WHO's Executive Board adopted resolution EB134.R5 on public health impacts of exposure to mercury and mercury compounds: the role of WHO and ministries of public health in the implementation of the Minamata Convention, which recommends that the Health Assembly welcome the adoption of the Convention by States.

intersectoral action – and commitment – is formalized, thereby ensuring the sustainability of the efforts and resources required to address them.

90. Monitoring and reporting on trends and progress made in addressing environmental and occupational determinants of health is a central contribution by WHO in the area of health and the environment, particularly in the context of the Millennium Development Goals and potential post-2015 sustainable development goals. Effective communication and coordination between the three levels of the Organization is essential to the successful delivery of results, particularly in countries where technical capacity is limited. To the extent possible, the alignment of work streams around overlapping issues can help to ensure continuity of activities in the face of resource shortfalls.

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

91. In 2012, the Health Assembly adopted resolution WHA65.6 on a comprehensive implementation plan on maternal, infant and young child nutrition, containing six global nutrition targets supported by the global nutrition community. A key objective for the biennium 2012–2013 has been to provide support to countries in reducing levels of childhood stunting, wasting and overweight, low neonatal birth weight and anaemia in women of reproductive age, and to increase exclusive breastfeeding.

92. The provision of guidance on effective nutrition programmes and scientific advice on nutrition and health has been extended to cover several micronutrients, acute malnutrition and communicable and noncommunicable diseases. Global estimates of child growth and malnutrition have been updated annually in collaboration with UNICEF and the World Bank and are currently used as measures of progress towards the achievement of global targets. A global nutrition monitoring framework has been drawn up and will be discussed with Member States in 2014, and a global monitoring system for nutrition policies and actions has been established.

93. Global initiatives, such as Scaling Up Nutrition and Nutrition for Growth promote global targets. In the African Region, 32 countries joined the Scaling Up Nutrition movement, which involves making a commitment to making the political environment supportive of nutrition and aligning governments and actors in order to expand nutrition actions. The Regional Committee for the Western Pacific at its Sixty-third session endorsed a set of key actions aimed at achieving global targets, and the Regional Committee for Europe Region, has requested the Regional Director to develop a new nutrition action plan for 2014–2020.

94. Technical support was provided to Member States for augmenting prevention and control of anaemia, treating acute malnutrition, and reducing the content of salt and *trans*- and saturated fatty acids in food, as well as for implementing the International Code of Marketing of Breast-milk Substitutes in both stable and emergency situations.

95. In the area of food safety, the Secretariat elaborated a strategic plan for food safety 2013–2022 that built on resolution WHA63.3 and was supported by three regional strategies.<sup>1</sup> The Codex Alimentarius Commission adopted new and revised food standards based on the scientific advice produced by WHO and FAO, and the Codex Trust Fund continued actively to support wider and

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<sup>1</sup> Advancing food safety initiatives: a strategic plan for food safety including foodborne zoonoses 2013–2022. Geneva: World Health Organization; 2014.

stronger participation by developing countries and countries in transition in Codex meetings. Further expansion of the International Food Safety Authorities Network (INFOSAN) at the global and regional level facilitated faster and more coordinated reporting of, and responses to, foodborne disease outbreaks. A global platform for food safety data and information (FOSCOLLAB) was launched to support evidence-based decision-making by facilitating access to multiple, varied data. WHO also contributed to the initial dose assessment and first health-risk assessment in the context of food safety following the Fukushima nuclear accident.

96. Surveillance systems and national laboratory capacity for food analysis and foodborne disease investigation were strengthened, through for example the Global Foodborne Infections Network; advances were made in food safety advocacy and education using the Five Keys to Safer Food; and a guidance document on the integrated surveillance of antimicrobial resistance was published.<sup>1</sup>

97. All six Organization-wide expected results were rated as “fully achieved”. Increased interest by Member States in nutrition and food safety contributed significantly to the achievement.

98. WHO’s technical leadership and normative work, coupled with its ability to engage multiple actors in expanding actions, have proved effective in advancing global nutrition. Lessons learnt from pilot testing a food safety needs assessment tool will help in identifying gaps and meeting countries’ future needs.

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

99. The strategic objective concerns the actions countries can take to strengthen their health systems overall as they seek to move closer to universal health coverage. It covers issues linked to the number, distribution and motivation of health workers; the best ways to ensure funding of health systems and that people can afford to use needed health services; the information and research required to develop evidence-based policies, including eHealth and mobile-health (mHealth) technologies; improving the range and quality of available health services; and governance and regulation across the health sector. Policy dialogue on national health plans and strategies, and their implementation and review, links all the components together. In some countries donor coordination and harmonization, frequently linked to the International Health Partnership (IHP+) is also crucial.

100. During the biennium 2012–2013, Member States sought to strengthen all branches of their health systems. A total of 95 countries reviewed or updated their national health strategies and plans and 60 established or strengthened donor coordination mechanisms to ensure alignment with national plans. Progress was made in improving service delivery, with 90 countries launching quality-of-care initiatives designed to improve the safety, patient focus and integration of health services. A total of 89 countries received technical and policy support to modify or review their health financing systems, and 59 enhanced the quality of their health information systems thereby improving the availability of health data for decision-making and increasing the attention paid to strengthening civil registration and vital statistics systems. Some 56 countries developed accountability frameworks and road maps to

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<sup>1</sup> Integrated surveillance of antimicrobial resistance: guidance from a WHO advisory group. Geneva: World Health Organization; 2013 ([http://www.who.int/foodsafety/publications/foodborne\\_disease/agisar\\_guidance/en/](http://www.who.int/foodsafety/publications/foodborne_disease/agisar_guidance/en/), accessed 27 March 2014).

follow up on the recommendations of the United Nations Commission on Information and Accountability for Women's and Children's Health.

101. Many countries made progress in reducing critical shortages of health workers and in improving their distribution, motivation and skills mix. Out of 57 countries with a health workforce crisis, 32 across all regions increased the number of health workers, and 37 out of the 56 countries that reported began implementing the WHO Global Code of Practice on the International Recruitment of Health Personnel. Countries continued to expand their use of health information and communications technologies, including different aspects of eHealth, such as electronic medical records, telemedicine and eLearning.

102. Major advances took place in the area of mobile telephone health (mHealth) applications, telemedicine and use of the Internet for health purposes. In 2012, the Secretariat launched a knowledge portal providing access to information about eHealth policies, strategies and regulatory frameworks, as well as knowledge management strategies developed in 85 countries. Access to biomedical and health literature through the Health InterNetwork Access to Research Initiative (HINARI) was expanded: more than 7000 journals are now available in 116 countries, including 41 in the African Region. Agreement was reached with a publishing partner to make more than 18 000 online books available in countries with a functioning HINARI programme. The Initiative's status as a public-private partnership was extended to 2020. In 2013, 114 countries participated in the second global eHealth survey and 65 countries in a survey on eHealth and women's and children's health.

103. Of the 13 Organization-wide expected results, nine were rated as "fully achieved" and four as "partly achieved". Organization-wide expected result 10.5 (better knowledge and evidence for health decision-making) was partly achieved because of limited capacity at country level to strengthen data analysis based on a robust national health policy, strategy or plan. Obstacles to the achievement of Organization-wide expected result 10.6 (national health research for development of health systems) included a shortage of researchers, weak research institutions and unfavourable research cultures. In the case of Organization-wide expected result 10.7 (knowledge management and eHealth policies and strategies developed), most countries did not have knowledge management strategies and eHealth continued to be driven by small or pilot projects. Organization-wide expected result 10.8 (health-workforce information and knowledge base strengthened) was only partly achieved because the indicator on the number of Member States reporting two or more national data points on human resources for health within the past five years, as reported in the Global Health Workforce Statistics, was not fully met. The method used to measure the indicator allows countries a five-year shifting window in which to report. Some countries that reported positively at the beginning of the five-year period reported negatively at the end of the period, thereby reducing the total number of countries from 127 to 122 countries.

104. During the biennium, the Secretariat had to respond to a growing number of requests for technical and policy support from Member States for health system strengthening in order to move closer to universal health coverage. The countries requesting support ranged from low-income countries facing the additional burden of noncommunicable diseases, mental health and injuries on top of the unfinished Millennium Development Goal agenda, to high-income countries trying to protect health and health spending from the prolonged effects of the financial crisis. Specified funding increased for policy dialogue on national health strategies and plans, financing for universal health coverage, and follow-up activities associated with the United Nations Commission on Information and Accountability for Women's and Children's Health in selected countries. Other elements of the strategic objective, including service delivery and patient safety, resource tracking and costing, information system strengthening, and research and knowledge management, were less well-funded.



105. Fragmentation of health systems remains a major problem in many countries and requires a concerted approach in order to build strong systems capable of ensuring the required range of quality health services across the life span that encompasses promotion, prevention, treatment, rehabilitation and palliative care. Such issues require active collaboration among priority health programmes and broader efforts to strengthen health systems. Making progress towards universal health coverage also requires frequent interaction between health ministries, finance ministries and political leaders. There is also a shortage of experts at country and global levels in some areas of health system strengthening, which limits the capacity of countries to make advances, as well as WHO's ability to respond to countries' needs. As a result, the Organization focused on capacity-building activities during the biennium.

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

106. Medical products account for nearly half the total health expenditures of Member States and up to 90% of the population in developing countries purchase health commodities through out-of-pocket payments. High prices, inability to pay, lack of social protection, inefficient supply management and weak regulatory and enforcement systems for essential medicines and health technologies are the major factors impeding universal access to health care. Improving access to essential medicines and health technologies is a prerequisite for universal health coverage and the achievement of international goals relating to the unfinished agendas for maternal and child health and communicable diseases targeted by the Millennium Development Goals. It is also crucial for tackling both the increasing burden of noncommunicable diseases and a rapidly ageing world population.

107. Guided by requests from Member States for support in implementing the provisions of resolutions adopted by the Executive Board and the Health Assembly and other global health strategies, the Secretariat continues to work closely with health and other ministries, academia, research and scientific institutions, professional associations, the private sector and international and national civil society organizations, and draws on its network of intercountry support teams, WHO collaborating centres, national professional officers and local and international experts. WHO continues to produce information, and, to date, 165 pharmaceutical sector country profiles have been made available to guide policy-makers at national and international levels. Twice yearly, WHO organizes one-week technical briefing sessions for advisers and partners from anglophone and francophone countries.

108. The strong and growing political commitment in countries to developing national health policies, strategies and plans has led to more systematic efforts to bring coherence to fragmented systems. WHO has provided technical assistance to more than 99 countries for preparing, revising and implementing national medicines policies and plans, or for developing specific health-system components. The WHO guideline on country pharmaceutical pricing policies<sup>1</sup> and the WHO traditional medicines strategy: 2014–2023<sup>2</sup> were launched, and WHO has started work on mapping and analysing the status of, and trends and methods used for, health technology assessments in Member States. The Good Governance for Medicines programme was operational in 44 countries at the end of 2013 (and continues to be so) and is increasing its accountability and transparency. The Second Global Forum on Medical Devices was held in 2013, and health professionals in countries are

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<sup>1</sup> WHO guideline on country pharmaceutical pricing policies. Geneva: World Health Organization; 2013.

<sup>2</sup> WHO traditional medicines strategy: 2014–2023. Geneva: World Health Organization; 2013.

now undergoing training in the 18 modules of the first WHO medical device technical series. The tenth World Blood Donor Day was marked in 2013. Although advances have been made in ensuring access to safe blood through donor screening and safe blood transfusion, low capacity for implementing haemovigilance systems remains a key challenge in many Member States.

109. WHO continues to coordinate implementation of the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property and is working to build country capacities for local production of medical products. In 2012, WHO, jointly with WIPO and WTO, published a major study on promoting access to medical technologies and innovation.<sup>1</sup> In follow-up to the Consultative Expert Working Group on Research and Development, WHO adopted a strategic work plan and undertook consultations with stakeholders to identify demonstration projects on the effectiveness of innovation. Furthermore, the *Priority medicines for Europe and the world update 2013 report*<sup>2</sup> identified gaps in, and priorities for, pharmaceutical research for 2014–2020.

110. The rational use of medicines, covering antimicrobial resistance, requires urgent attention. In April 2013 the Expert Committee on the Selection and Use of Essential Medicines adopted the 18th WHO Model List of Essential Medicines<sup>3</sup> and the 4th WHO Model List of Essential Medicines for Children,<sup>4</sup> which together with the *WHO Model Formulary* guide countries in selection and rational use. There is a growing interest in rational selection and use of health commodities in all regions and the Ministers' Summit on the benefits of the responsible use of medicines: setting policies for better and cost-effective healthcare (Amsterdam, the Netherlands, 3 October 2012), reviewed the significant missed potential in the way medicines are used. WHO's Better Medicines for Children initiative has made progress in increasing the availability of paediatric medicines in child-friendly formulations and correct dosages, and various tools are now being made available to countries and organizations of the United Nations system, including means of prioritizing medicines and medical devices for maternal and child health and guidance on regulatory pathways for paediatric medicines. WHO has provided technical leadership in the formulation of the 13 recommendations of the United Nations Commission for Life-Saving Commodities for Women and Children and their implementation in eight path-finder countries. The increase in noncommunicable diseases and a rapidly ageing population create a need for improved access to palliative care and pain relief. The Expert Committee on Drug Dependence met in 2012 to review substances for possible scheduling under the international drug control treaties and WHO has published guidelines on the pharmacological treatment of persisting pain in children;<sup>5</sup> another two sets of guidelines on the treatment of persisting and acute pain in adults are being prepared.

111. Quality in medical products is one of the cornerstones of health care and has a major impact on access and costs. WHO has provided support to 125 countries to develop national plans and build capacities for strengthening regulatory oversight of vaccines, immunization, medical equipment and

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<sup>1</sup> Promoting access to medical technologies and innovation: intersections between public health, intellectual property and trade. Geneva: World Health Organization, World Intellectual Property Organization and World Trade Organization; 2013.

<sup>2</sup> Kaplan W, Wirtz V, Mantel A, Stolk P, Duthey B, Laing R. Priority medicines for Europe and the world: update 2013 report. Geneva: World Health Organization; 2013.

<sup>3</sup> [http://apps.who.int/iris/bitstream/10665/93142/1/EML\\_18\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/93142/1/EML_18_eng.pdf?ua=1), accessed 28 March 2014.

<sup>4</sup> [http://www.who.int/medicines/publications/essentialmedicines/4th\\_EMLc\\_FINAL\\_web\\_8Jul13.pdf](http://www.who.int/medicines/publications/essentialmedicines/4th_EMLc_FINAL_web_8Jul13.pdf), accessed 28 March 2014.

<sup>5</sup> WHO guidelines on the pharmacological treatment of persisting pain in children with medical illness. Geneva: World Health Organization; 2012.

selected biologicals. During the biennium, WHO organized two international meetings of world pharmacopoeias to discuss and outline steps for increasing convergence in quality standards; and an initiative to develop a consolidated assessment tool for national regulatory authorities across medicines, diagnostics, devices and vaccines was recently launched. In 2013, the three WHO prequalification programmes for diagnostics, medicines and vaccines were combined into one. WHO has ensured the availability of another 110 prequalified priority medicines for treatment of HIV/AIDS, malaria and tuberculosis and for promoting reproductive health, the Organization has also prequalified 43 active pharmaceutical ingredients, seven quality control laboratories, 16 vaccines, 17 diagnostics and one medical device. Another 21 new International Chemical Reference Substances and 11 reference preparations were established and made available as physical standards against which national quality control laboratories can test medicines; and 50 global specifications, monographs and general texts were approved by the Expert Committee on Specifications for Pharmaceutical Preparations and published for inclusion in the International Pharmacopoeia. The Expert Committee on Biological Standardization approved another nine written standards and eight reference preparations for vaccines and biotherapeutic products. The WHO International Nonproprietary Names programme gave generic names to a further 293 medicines, bringing the total to 8900. The first two meetings of the Member State mechanism on substandard/spurious/falsely-labelled/falsified/counterfeit medical products, held in 2012 and 2013, represented a determination on the part of the international community to tackle the growing challenge of such products. The newly established rapid alert system for reporting instances of substandard/spurious/falsely-labelled/falsified/counterfeit medical products will allow structured and systematic reporting and a more accurate assessment of the scope, scale and harm caused by such products. Another seven countries joined the WHO Programme for International Drug Monitoring, which, through its network of pharmacovigilance centres, monitors the safety of medicines use. The Global Vaccine Safety Initiative, established in 2012, ensures implementation of the Global Vaccine Safety Blueprint, which is WHO's strategic plan for building national capacities to monitor vaccine safety.

112. Of the three Organization-wide expected results, one has been “fully achieved” and two “partly achieved”. Political unrest, tight earmarking of available funds, high turnover of government officials, and underfunded national health systems were main reasons for the suboptimal results for certain activities, which affected the overall ratings for the Organization-wide expected result. In addition, significant “pockets of poverty”, including for normative work to improve access to medical products, have a negative impact on the reach and effectiveness of the Organization.

113. There is a clear link between increased commitment to moving closer to universal health coverage and a growing recognition among Member States of the importance of efficiently-functioning medicine and health technology systems. More regional networks and intercountry work processes are being established for sharing information and experiences and addressing specific topics. Collaborative initiatives and the availability of national focal points and country advisers have increased the effectiveness of implementation and made interventions sustainable, as evidenced by noticeable achievements in several regions where full-time medicine and health technology advisors enabled the Secretariat to respond to country requests and deliver technical advice and support. Integrated health systems must be used as a common approach in addressing disease-specific and vertical programmes in order to improve the integration of services.

114. Capacity to regulate medical products varies between regions and many Member States still require substantial technical support to meet international requirements. Many regulatory capacity-building activities are undertaken under the umbrella of the WHO Prequalification Programme; however, WHO's current human resources' capacity and available funding are insufficient and new strategies will be required to achieve significant and sustainable improvements in regulatory performance. Renewed attention will also be required in order to intensify efforts to improve access

and promote rational use of medicines and health technologies, and to ensure that initiatives to improve access to medical products across disease-specific and vertical programmes are coordinated under a common approach. Expanding rational use of medicines to combat antimicrobial resistance, cost containment of medical products, and health technology assessment are other emerging priorities that will affect the return on global investments in health. Comprehensive regional laboratory quality assurance programmes are lacking and shortages of blood occur frequently in many Member States.

**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 2006–2015**

115. Achievements were made in the biennium 2012–2013 within the programmatic, governance and management areas of WHO reform towards the objectives of better health outcomes, increased coherence in global health, and improving organizational excellence. Programmatic reforms were marked by the development of organizational priorities by Member States, which formed the basis of the development of the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2014–2015, approved by the Sixty-sixth World Health Assembly.<sup>1</sup> The Twelfth General Programme of Work identifies six leadership priorities that give focus and direction to WHO's work, by highlighting areas in which WHO's advocacy and technical leadership in the global health arena are most needed, and driving the way the Organization works – integrating efforts across and between the three levels of WHO, as well as through the Organization.

116. Governance reforms progressed at a slower pace, but there have been improvements in enhancing the roles and functions of the governing bodies. Progress included: strengthening the oversight role of the Programme, Budget and Administration Committee of the Executive Board; increasing the efficiency of the governing bodies through better time management and electronic distribution of documents; harmonization of the procedures of the regional committees; and alignment of the agendas of the regional committees, Executive Board and Health Assembly. Regular briefings enabled Member States more effectively to influence and participate in decision-making in governing bodies meetings. Internal governance was reinforced by regular meetings of the Global Policy Group (comprising the Director-General, Deputy Director-General and regional directors), and other senior staff network meetings.

117. The main elements of a new framework of engagement with non-State actors were elaborated through a process involving multiple stakeholders, which included consultations with Member States and non-State actors, a public web-based consultation, and several debates in governing bodies meetings.<sup>2</sup> However, detailed policies related to the new framework still have to be formulated and agreed.

118. In 2013, a report on WHO's arrangements for hosting health partnerships and proposals for harmonizing WHO's work with hosted partnerships was considered by the Executive Board.<sup>3</sup> It listed major developments in hosted partnerships and summarized hosting relationships. At the request of the Executive Board in decision EB132(10), the Secretariat prepared a paper for the Programme,

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<sup>1</sup> Resolution WHA66.1.

<sup>2</sup> See documents EB130/5 Add.4, A65/5, EB132/5 Add.2, EB133/16 and, for example, EB133/2013/REC/1, summary records of the second meeting (section 5) and third meeting (section 1) of the Executive Board at its 133rd session.

<sup>3</sup> See document EB132/5 Add.1.

Budget and Administration Committee on a proposed approach for the conduct of reviews of hosted partnerships as a basis for review by the Committee.<sup>1</sup> Work on modalities to ensure the full and transparent recovery of costs associated with hosted partnerships is expected to be carried out in 2014 and applied to hosted partnerships as appropriate. Several hosted partnerships have conducted independent evaluations of their programmatic performance and activities under the auspices of their respective boards. A working group of WHO and partnership secretariat staff has been established to formulate internal guidelines for coordinating regional and country activities of hosted partnerships with those of WHO programmes. The guidelines will further inform WHO's engagement. The Health Metrics Network was dissolved in May 2013.

119. At the managerial level, several reforms progressed to implementation stage while others remained at the policy analysis stage. Significant progress was made on WHO financing mechanisms, and the Financing Dialogue meetings in 2013 were decisive in the shift towards greater predictability, flexibility, alignment and transparency of WHO resources. Progress in managerial reforms in the areas of human resources, finance and accountability is reported under strategic objective 13.

120. Some progress was made in better aligning WHO's work at country level with country needs, through the revision of country cooperation strategies. The strategies are now being revised to align with the Twelfth General Programme of Work leadership priorities, and linked to the revised WHO results chain. A network of country offices in the BRICS countries (Brazil, Russian Federation, India, China and the South Africa) has worked effectively in ensuring an active exchange of knowledge and experience between country offices across regions. As part of the process of strengthening WHO's performance in countries, support has been provided to heads of WHO offices for becoming active members of United Nations Country Teams. Updates and guidance were provided on standard operating procedures, the Delivering as One strategy, United Nations Resident Coordinator funding modalities, and strengthening of the United Nations Development Assistance Framework. In 104 of the 116 countries, territories and areas where WHO has a presence, WHO field offices acted as chair or co-chair of the Thematic Group on Health. The 7th Global Meeting of Heads of WHO Offices, attended by the Director-General and regional directors, was held in 2013, highlighted the continuing need to strengthen WHO's presence in countries and support national programmes.

121. Following the adoption of the evaluation policy, articulated pursuant to resolution WHA64.2 on WHO reform, efforts were directed towards its operationalization through both the central evaluation function and the Global Network on Evaluation whose remit is to promote both evaluation as a means of improving programme performance and accountability for results and the application of evaluation as a practice across WHO, and to build capacity where needed. A major output was the development of an evaluation practice handbook, which provides a step-by-step guide to the different roles and responsibilities within the field of evaluation, the use of harmonized tools and methods, and associated quality control mechanisms.<sup>2</sup> An improved infrastructure for reporting evaluation outputs has also been introduced to enhance information-sharing and the use of lessons learnt for evidence-based planning. The initial Organization-wide evaluation work plan for 2014–2015 was developed and submitted to, and noted by, the Executive Board in January 2014.<sup>3</sup>

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<sup>1</sup> See documents EBPBAC19/8 and EB134/3 which were noted by the Executive Board at its 134th session (summary records of the sixth meeting, document EB134/2014/REC/2).

<sup>2</sup> WHO evaluation practice handbook. Geneva: World Health Organization; 2013.

<sup>3</sup> See documents EB134/38 and EB134/2014/REC/2, summary record of the tenth meeting, section 2.

122. After more than a decade, in 2012–2013 the Communications Department was re-established in the Director-General's office, signalling a new approach to communications that mirrors global trends. Among the benefits of the centralized approach are improved coordination within the communications team in carrying out the Organization's work, and availability of the necessary communication surge capacity at country, regional and headquarters levels. This was evidenced by the development of WHO's first emergency communications network, which will train communications experts to deploy rapidly in public health emergencies in order to provide communications support within countries and regions. In 2013, half those trained were deployed successfully in emergencies. The new Communications Department inspired a more proactive and collaborative working relationship with the media covering public health issues through media fellowships, editorial boards and other networking and educational opportunities for supporting journalists in order to encourage more accurate coverage of health issues. It also played a key role in creating the Organization's first corporate social media team. The number of "followers" has grown exponentially, giving a strong indication of the public's interest in a more central role for WHO in communicating health information. In January 2012, the corporate Twitter account had 311 000 followers and by the end of 2013 the number had risen to 1 million. Facebook, Google+, YouTube and Instagram are also used as tools to reach new audiences. The key to effective communications campaigns is identifying what people want and sharing information that is useful to them. The WHO website refined new tools for collecting useful and relevant feedback in order to adjust and customize information and messaging to the needs of its audience so as to enhance their impact, timeliness and usefulness in all six official languages. The first global perception survey, conducted in 2013, provided additional feedback on stakeholders' needs and will serve as a baseline for measuring future progress.

123. All four Organization-wide expected results are rated as "fully achieved". Overall, progress was made in the three broad, complementary areas of leadership in global health through: enhanced governance, coherence and accountability; WHO's support for, presence in, and engagement with individual Member States; and its role in positioning health as a subject of global and regional importance.

124. The achievement of the four Organization-wide expected results marks the completion of a significant phase in the Secretariat's reform process. Stepwise advances were made in the reform of governance, programmes and management. In 2014–2015, reform efforts will be catalysed through a more strategic approach. The focus will be on enhancing country performance through a revised country cooperation strategy framework aligned with country needs and priorities. Capacity in country offices will be further strengthened to enable them effectively to deliver WHO's leadership priorities, and to broker and provide technical and policy support and advice.

125. More work is needed to further strengthen WHO's governance role, build governance capacity and deepen the reform of management policies, systems and practices. Even though a new evaluation framework was developed and a Compliance, Risk Management and Ethics Department established, efforts in building a more coherent and accountable Organization need to be consolidated. Better alignment of the work of the three levels of the Organization through efficient and effective programme coordination mechanisms and communications strategies should be given more attention in 2014–2015 in order to enhance WHO's performance within countries. At the country level, country cooperation strategies need to be aligned with the health plans and strategies of individual countries, as well as with United Nations Development Assistance Framework processes. The establishment of a new model to finance the work of WHO, together with the alignment of the priorities agreed by its governing bodies with adequate funds, and the provision of required resources for potential shifts, are actions to be undertaken next. It is recognized that resource mobilization requires further work, including on the best way to use the three levels of the Organization. With the adoption of a new results-based framework, it is now possible to carry out more systematic and objective assessments of

progress in categories and programme areas that contribute to the achievement of results, and alignment of output deliveries with use of resources.

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

126. Administrative and management support services are functions that enable the Organization to carry out its mandate. During the biennium 2012–2013, the main focus was on the various elements of WHO reform, especially in the programmatic and managerial areas.

127. A highlight of the biennium was the development of the new results-based management framework in line with WHO reform and in consultation with Member States. The framework provides a clear results chain and delineates the deliverables at the three levels of the Organization, with particular emphasis placed on reflecting the priorities defined in the country cooperation strategies. The vision of the Organization as described in the Twelfth General Programme of Work 2014–2019, and the scope of the work included in the Programme budget 2014–2015 are also reflected in the new framework.

128. In that context, approval of the Programme budget 2014–2015 in its entirety and the Financing Dialogue process to fund the budget are key achievements under the managerial pillar of WHO reform.

129. In addition, the Secretariat is reviewing the budgets for strategic objectives 12 and 13, as well as actual costs, in order to ensure appropriate financing of management and administrative costs. The review covers existing financing arrangements, such as programme support costs and post occupancy charges, and possible alternative methods for cost recovery. A proposal to that end was presented to the Programme, Budget and Administration Committee at its 19th meeting in January 2014. A revised version is submitted to the Health Assembly for its consideration in document A67/10.

130. Another achievement was the full implementation of the International Public Sector Accounting Standards, a process that was completed in 2012. WHO was certified as fully compliant with the standards by the External Auditors in 2013, thus raising the standard of financial reporting and transparency in the Organization.

131. Another reform initiative to increase accountability and improve internal controls, some elements of which were completed in 2012–2013, was the development of a global set of standard operating procedures and new monitoring tools, including the management dashboard. A new internal control framework was finalized at the end of 2013 and is now being implemented. It includes the re-definition of managerial roles and responsibilities across the Organization and reinforced accountability for delegation of authority. The Joint Inspection Unit conducted a special review of WHO's management, administration and decentralization<sup>1</sup> as part of the ongoing efforts of Member States and the Secretariat to reform fundamental aspects of the Organization's operations.

132. In the area of human resources management, a new strategy has been developed and presented to Member States based on three pillars (attracting talent, retaining talent and creating an enabling working environment) and four cross-cutting principles (gender balance, diversity, collaboration and accountability).

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<sup>1</sup> See document EB132/5 Add.6. Annex.

133. An approach to harmonizing information communications technologies globally was devised and a series of shared service initiatives was launched. Access to better quality administrative data through the Global Management System has improved transparency in the Organization's work. The system underwent a technical upgrade in 2013 and a transformation initiative is being launched to enhance its functionalities over the next two biennia. A new information technology strategy was developed and has been positively received by Member States.

134. A major achievement under strategic objective 13 was the delivery of cost savings, while maintaining service levels and quality and realizing the pertinent objectives. Overall, WHO incurred expenses of US\$ 481 million for strategic objective 13 in 2012–2013, compared to US\$ 540 million in 2010–2011. In some cases, the reduction resulted from the re-categorization of costs to other strategic objectives, but it is estimated that underlying savings of US\$ 40 million were made as a result of offshoring, outsourcing and reorganization of work. The savings were spread across all parts of the Organization, with headquarters accounting for a slightly higher proportion.

135. Two of the six Organization-wide expected results have been “fully achieved” and four “partly achieved”. Organization-wide expected result 13.2 (sound financial practices and efficient management of financial resources) was rated as “partly achieved” because the target amount of US\$ 400 million in voluntary contributions classified as fully and highly flexible was not reached. Only US\$ 264 million were recorded in 2012–2013 as contributors have been waiting until the proposed new financing model, especially the role of the Financing Dialogue, becomes clearer. Organization-wide expected result 13.3 (human resources policies and practices) was “partly achieved”; in future the area will benefit from the new human resources strategy and initiatives on mobility and performance management. Despite an improvement on the January 2012 baseline value (from 85% in 2012 to 90% at the end of 2013), indicator 13.5.1 on the proportion of services delivered by the Global Service Centre according to published service level Indicators was not fully achieved because of backlogs in dealing with human resources transactions. Therefore, Organization-wide expected result 13.5 (managerial and administrative support services) was rated as “partly achieved”. Funding issues linked to the Real Estate Fund affected the achievement of indicator 13.6.2 on the level of funding and execution of the biennial Capital Master Plan and were responsible for the partial achievement of Organization-wide expected result 13.6 (working environment conducive to the well-being and safety of staff in all locations). Although compliance with United Nations minimum operating security standards has improved, especially in the African and Eastern Mediterranean regions, overall achievement of indicator 13.6.1 was recorded as 85% instead of the targeted 95%.

136. The main focus of the enabling functions of the Organization will remain on initiatives linked to the managerial component of the WHO reform agenda. Therefore, work will continue on accountability and internal controls, strategic resource allocation, financing (including management and administrative costs), human resource policies and management, and Global Management System transformation. Training on internal control measures will be essential for the successful implementation of the internal control framework across the three levels of the Organization. The framework will be further complemented by the new accountability framework, the revised delegation of authority procedure and a strengthened risk management approach.

137. In the area of human resources, WHO will continue to implement the revised strategy in order to build a workforce that meets the Organization's evolving staffing needs. Mobility and performance management will be two essential components of the implementation effort, as well as the new management development programme and the global roll-out of the learning management system.

138. A long-term strategy for the future functioning of the Global Service Centre and a revised governance model need to be elaborated with a view to achieving further savings and service



improvements across WHO. Such a vision could include: reviewing and optimizing major end-to-end processes; further investment in the Global Service Centre through additional transfers of tasks and consolidation of back-office activities, especially in order to eliminate duplication and inefficiency; and leveraging the Global Management System to provide targeted key additional functionalities, improve reporting and reduce manual processing.

## OVERVIEW OF FINANCIAL IMPLEMENTATION

139. In May 2011, the Sixty-fourth World Health Assembly adopted resolution WHA64.3, the appropriation resolution for the financial period 2012–2013, and noted the total effective budget of US\$ 3959 million, presented in three segments: base programmes (US\$ 2627 million); special programmes and collaborative arrangements (US\$ 863 million); and outbreak and crisis response (US\$ 469 million), to be financed from assessed contributions, voluntary contributions and carry-over funds from the financial period 2010–2011.

140. At the end of the biennium 2012–2013, the financing available for all segments of the budget, including both assessed and voluntary contributions, was US\$ 4210 million, comprising: income of US\$ 1000 million received in 2010–2011 and planned for 2012–2013; income planned and carried forward from 2010–2011 of US\$ 500 million; and new income of US\$ 2710 million for 2012–2013, including US\$ 916 million in assessed contributions, and US\$ 1794 million in new voluntary contributions for the biennium. Out of the available funding, US\$ 1170 million (28%) was made up of assessed contributions and other flexible funding, whereas US\$ 3040 million (72%) was earmarked funding.

141. The total implementation<sup>1</sup> was US\$ 3914 million, or 99% of the approved budget, confirming the realistic nature of the Programme budget 2012–2013, which was based on the income and expenditure projections for the financial period. Although the level of financing for the total budget was good, financing was not evenly distributed across all budget segments, affecting levels of implementation by major office, strategic objective and budget segment, and highlighting the problems created by the high level of earmarked funding and inadequacy of flexible funding.

142. The following tables and figures show how the Programme budget 2012–2013 was implemented by budget segment, strategic objective and major office.

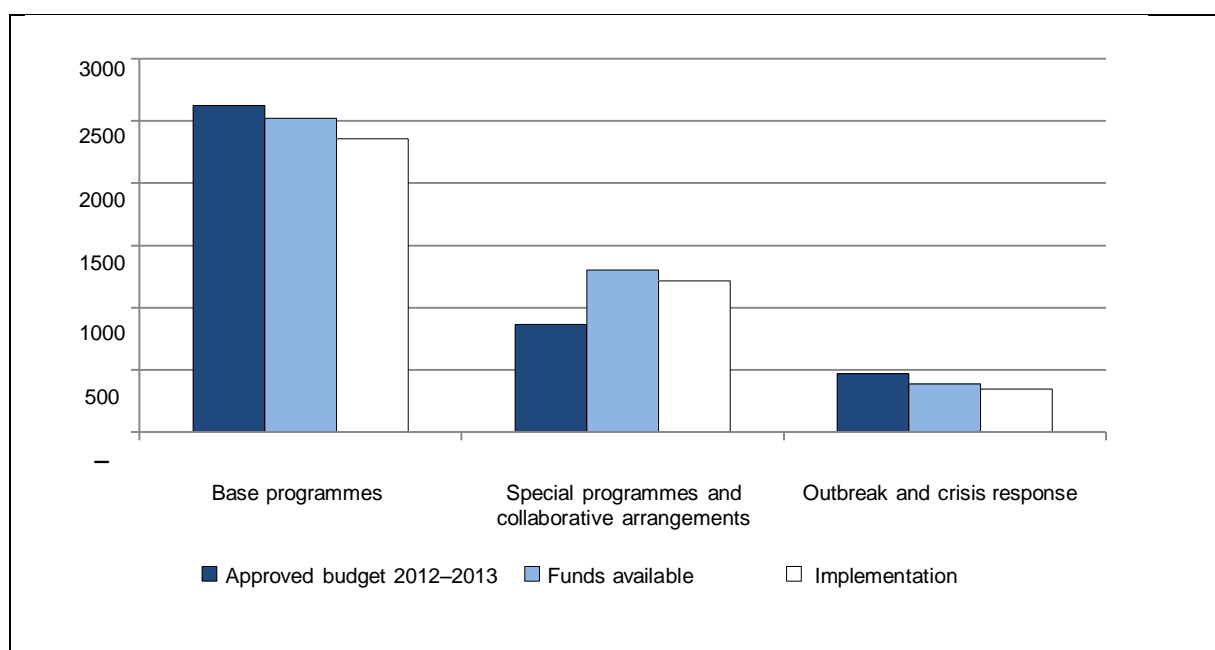
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<sup>1</sup> Implementation: this figure represents expenditure and encumbrances relating to results in the Programme budget 2012–2013 only.

**Table 2. Financial implementation by budget segment  
(US\$ million as at 31 December 2013)**

Segment	Approved budget 2012–2013	Funds available			Funds available as % of approved budget	Implementation	Implementation as % of approved budget	Implementation as % of funds available
		Assessed contributions	Voluntary contributions	Total				
Base programmes	2 627	913	1 611	2 524	96	2 359	90	93
Special programmes and collaborative arrangements	863	2	1 300	1 302	151	1 212	140	93
Outbreak and crisis response	469	1	383	384	82	343	73	89
<b>Total</b>	<b>3 959</b>	<b>916</b>	<b>3 294</b>	<b>4 210</b>	<b>106</b>	<b>3 914</b>	<b>99</b>	<b>93</b>

**Figure 1. Financial implementation by budget segment (US\$ million as at 31 December 2013)**



143. In 2012–2013, WHO continued to track financing and financial implementation according to the three budget segments, and the tables presented in this document provide a management analysis of the budget from this perspective. The three budget segments offer a useful lens through which to view the budget, in particular, for understanding the reasons for different levels of financing for different areas of the approved budget.

144. Table 2 and Figure 1 show financial implementation by budget segment. The funds available<sup>1</sup> for the base programmes segment were: US\$ 2 524 million (96% of the approved budget); for the

<sup>1</sup> 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.

special programmes and collaborative arrangements segment, US\$ 1302 million (151% of the approved budget); and for the outbreak and crisis response segment, US\$ 384 million (82% of the approved budget).

145. The base programmes segment was slightly under-funded against the approved programme budget with a gap of US\$ 103 million. However, the level of funding for the special programmes and collaborative arrangements segment exceeded the approved programme budget by US\$ 439 million. The increase in financing beyond the approved budget for the special programmes and collaborative arrangements segment continued to be related mainly to work on poliomyelitis eradication under strategic objective 1.

146. Activities under the outbreak and crisis response segment and its financing are mainly driven by emergencies and outbreaks, which are, by their nature, unpredictable. 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 were estimated at US\$ 469 million. Eventual funding amounted to US\$ 384 million, of which 89%, or US\$ 343 million, had been implemented by 31 December 2013.

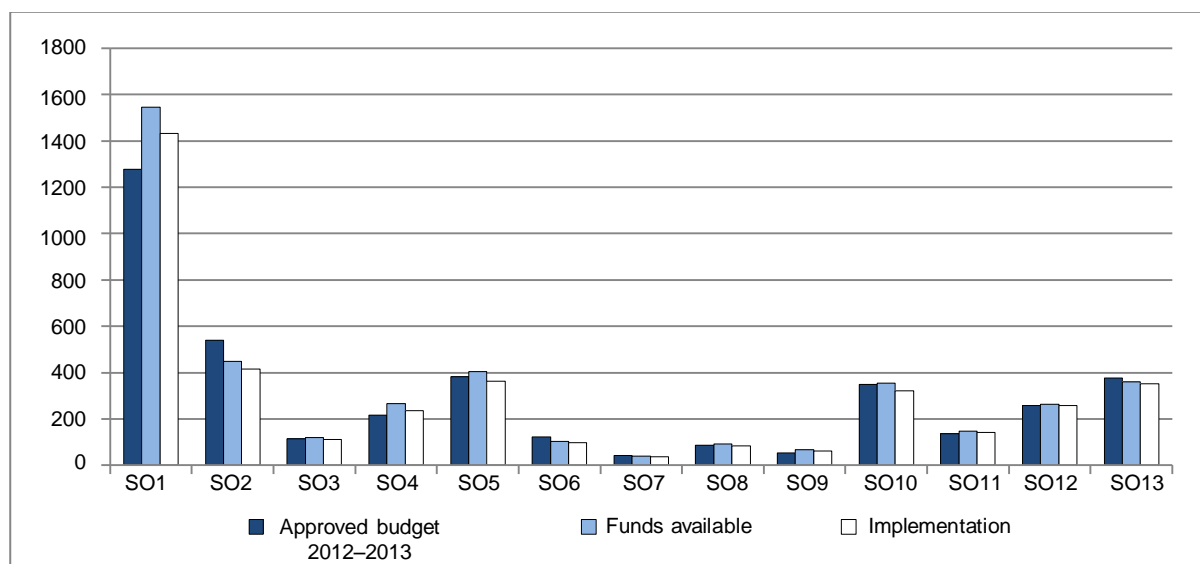
147. Implementation was 90% of the approved programme budget for base programmes, 140% for special programmes and collaborative arrangements, and 73% for outbreak and crisis response.

**Table 3. Financial implementation by strategic objective for all segments  
(US\$ million as at 31 December 2013)**

Strategic objective	Approved budget 2012–2013	Funds available			Funds available as % of approved budget	Implementation	Implementation as % of approved budget	Implementation as % of funds available
		Assessed contributions	Voluntary contributions	Total				
SO1	1 278	75	1 470	1 545	121	1 432	112	93
SO2	540	43	405	448	83	415	77	93
SO3	114	44	76	120	105	112	98	94
SO4	218	54	212	266	122	237	109	89
SO5	382	18	387	405	106	364	95	90
SO6	122	35	68	103	84	97	79	94
SO7	43	21	19	40	92	38	89	97
SO8	87	30	61	91	105	85	98	94
SO9	55	21	46	67	122	62	113	92
SO10	348	142	212	354	102	322	93	91
SO11	137	30	119	149	109	141	103	95
SO12	258	198	65	263	102	257	100	98
SO13 <sup>a</sup>	377	205	156	361	96	352	93	98
<b>Total</b>	<b>3 959</b>	<b>916</b>	<b>3 294</b>	<b>4 210</b>	<b>106</b>	<b>3 914</b>	<b>99</b>	<b>93</b>

<sup>a</sup> As well as the approved programme budget figure shown for strategic objective 13 in Table 3, an additional US\$ 138 million of related costs was financed through a separate cost-recovery mechanism under strategic objective 13bis (see Programme budget 2012–2013, Annex 1). These costs are included in Table 3 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 on all strategic objectives.

**Figure 2. Financial implementation by strategic objective for all segments  
(US\$ million as at 31 December 2013)**



148. Table 3 and Figure 2 show financial implementation by strategic objective. Funding for all strategic objectives exceeds the approved programme budget with the exception of strategic objectives 2, 6, 7 and 13. In the case of strategic objective 1, the over-funding is explained by an increase in the funding received for the special programmes and collaborative arrangements segment, especially for activities related to polio eradication. Strategic objectives 4 and 9 were also well funded against the budget which had experienced a greater than average reduction compared to the previous biennium. Both these strategic objectives also received additional funding under the special programmes and collaborative arrangements segment, namely for research in human reproduction under strategic objective 4, and for the Codex Alimentarius Commission under strategic objective 9.

**Table 4. Financial implementation by strategic objective for base programmes only  
(US\$ million as at 31 December 2013)**

Strategic objective	Approved budget 2012–2013	Funds available			Funds available as % of approved budget	Implementation	Implementation as % of approved budget	Implementation as % of funds available
		Assessed contributions	Voluntary contributions	Total				
SO1	446	75	361	436	98	397	89	91
SO2	446	43	299	342	77	316	71	92
SO3	114	44	76	120	105	112	98	93
SO4	186	52	161	213	114	191	103	90
SO5	65	17	36	53	83	51	78	96
SO6	111	35	58	93	84	88	79	95
SO7	42	21	19	40	93	38	90	95
SO8	87	30	61	91	105	86	99	95
SO9	51	21	42	63	123	58	114	92
SO10	322	142	191	333	103	303	94	91
SO11	122	30	87	117	96	110	90	94
SO12	258	198	65	263	102	257	100	98
SO13 <sup>a</sup>	377	205	155	360	96	352	93	98
<b>Total</b>	<b>2 627</b>	<b>913</b>	<b>1 611</b>	<b>2 524</b>	<b>96</b>	<b>2 359</b>	<b>90</b>	<b>93</b>

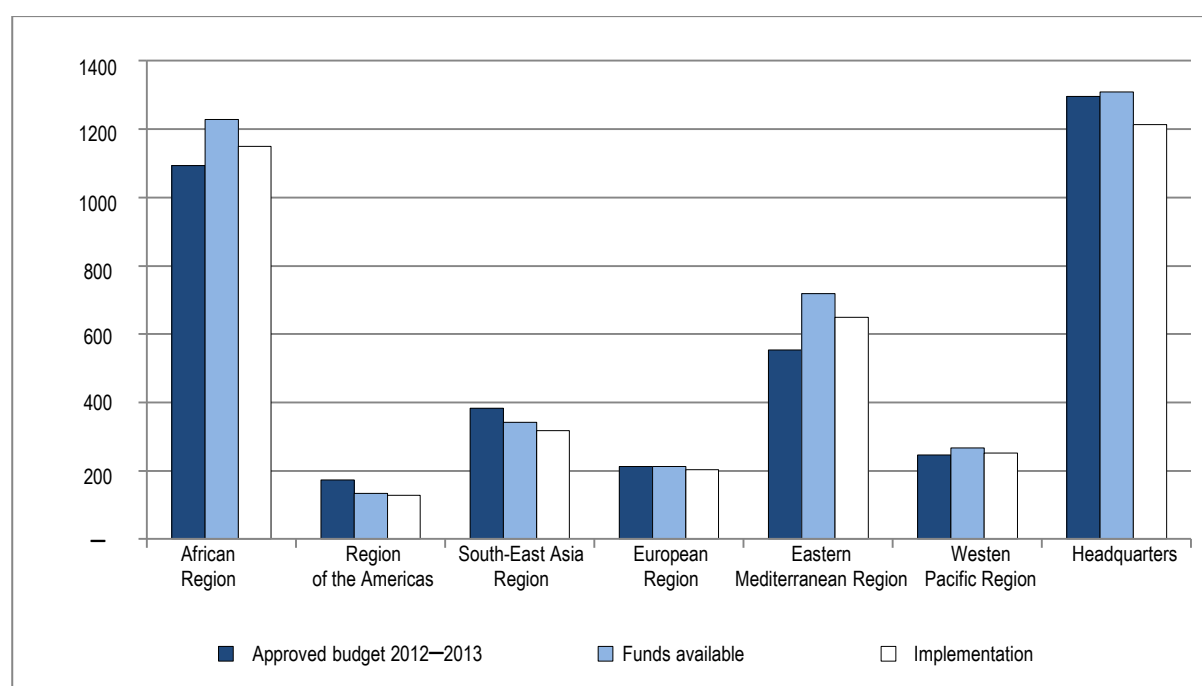
<sup>a</sup> As well as the approved programme budget figure shown for strategic objective 13 in Table 3, an additional US\$ 138 million of related costs was financed through a separate cost-recovery mechanism under strategic objective 13*bis* (see Programme budget 2012–2013, Annex 1). These costs are included in Table 3 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 on all strategic objectives.

149. Table 4 shows the base programmes segment of the programme budget by strategic objective as at 31 December 2013. The average funding available for all strategic objectives was 96%. The funding of strategic objectives varied from 77% for strategic objective 2 to 123% for strategic objective 9. The average implementation rate against the programme budget for the base programmes segment was 90% for all strategic objectives. Implementation rates ranged from 71% for strategic objective 2 to 114% for strategic objective 9, with the variation being mainly attributable to the effect of continued misalignment of the available funds.

**Table 5. Financial implementation by major office all segments  
(US\$ million as at 31 December 2013)**

Location	Approved budget 2012–2013	Funds available			Funds available as % of approved budget	Implementation	Implementation as % of approved budget	Implementation as % of funds available
		Assessed contributions	Voluntary contributions	Total				
African Region	1 093	204	1 025	1 229	112	1 149	105	93
Region of the Americas	173	80	53	133	77	129	75	97
South-East Asia Region	384	99	242	341	89	317	82	93
European Region	213	60	153	213	100	204	95	95
Eastern Mediterranean Region	554	88	631	719	130	650	117	90
Western Pacific Region	246	76	191	267	109	251	102	94
Headquarters	1 296	309	999	1 308	101	1 214	94	93
<b>Total</b>	<b>3 959</b>	<b>916</b>	<b>3 294</b>	<b>4 210</b>	<b>106</b>	<b>3 914</b>	<b>99</b>	<b>93</b>

**Figure 3. Financial implementation by major office (US\$ million as at 31 December 2013)**



150. Table 5 and Figure 3 show financial implementation by major office. By office, the funds available against the approved budget ranged between 77% for the Regional Office for the Americas and 130% for the Regional Office for the Eastern Mediterranean, and implementation ranged between 90% and 97% of the available resources. The high availability of funds in some major offices is partly explained by the high proportion of funds for the special programmes and collaborative arrangements segment, including polio eradication, especially in the African and Eastern Mediterranean regions. It also reflects a degree of success for the Organization's resource management reform efforts, which were launched during 2012–2013.

**Table 6. Financial implementation by major office for base programmes only  
(US\$ million as at 31 December 2013)**

Location	Approved budget 2012–2013	Funds available			Funds available as % of approved budget	Implementation	Implementation as % of approved budget	Implementation as % of funds available
		Assessed contributions	Voluntary contributions	Total				
African Region	641	204	339	543	85	504	79	93
Region of the Americas	161	80	39	119	74	116	72	97
South-East Asia Region	279	98	128	226	81	211	76	93
European Region	192	60	132	192	100	184	96	96
Eastern Mediterranean Region	232	88	172	260	112	234	101	90
Western Pacific Region	222	76	175	251	113	237	107	95
Headquarters	900	307	626	933	104	873	97	94
<b>Total</b>	<b>2 627</b>	<b>913</b>	<b>1 611</b>	<b>2 524</b>	<b>96</b>	<b>2 359</b>	<b>90</b>	<b>93</b>

151. Table 6 highlights base programmes by major office. The average level of funding available for all offices was 96%, which varied between 74% for the Regional Office for the Americas and 113% for the Regional Office for the Western Pacific. The average implementation rate against the programme budget for the base programmes segment was 90% for all offices. Implementation rates ranged from 72% in the Region of the Americas to 107% in the Western Pacific Region, with the variation being mainly attributable to the availability of funds.

152. The analysis highlights several points:

- achievement of full financing of the Programme budget 2012–2013;
- confirmation of the overall, more realistic budget for 2012–2013, which closely matched both the funding available and expenditure projections;
- an acceleration in the overall implementation of activities during the second year of the biennium;
- slight under-implementation against the Programme budget 2012–2013 available funding, which can be explained by:
  - continuation of the cost-saving measures introduced in 2010–2011 into the current biennium resulting in a further reduction in salary expenditures;
  - further savings generated by other efficiency measures, especially in headquarters;
  - conservative spending by managers in the current financial climate;

- almost full achievement of base segment financing and related implementation and over-financing of the special programmes and collaborative arrangements segment and related implementation, together with almost full achievement of the requirements of financing under the outbreak and crisis response segment;
- continued conservatism of spending in a financially cautious environment; and
- the need to build on, increase and accelerate improvements in the alignment of resources in order to ensure full achievement of the approved programmatic outcomes requested by Member States.

#### **ACTION BY THE HEALTH ASSEMBLY**

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

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