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WHO PROGRAMMATIC AND FINANCIAL REPORT FOR 2014-2015

including audited financial statements for 2015

World Health Organization

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[1] Including the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases.

[2] Including the the UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction.

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FOREWORD

For the first time, the WHO financial report for 2014–2015 is being combined in a single document with an assessment of organizational performance during the biennium. This is a logical evolution at a time of ongoing reforms at WHO and in a health development climate that places a premium on transparency, accountability and measurable results. By drawing together material previously issued in separate reports, the document lets readers see how the financial resources requested by WHO are being used to make progress in achieving planned results.

Information is presented in two parts. The first part begins with an overview of the major health challenges that emerged during the biennium and how WHO responded. An assessment of organizational performance under the six leadership priorities, identified in the Twelfth General Programme of Work, 2014–2019, is also included. Failures as well as successes are frankly presented. The most extensive section uses selected activities to illustrate each programme area under the six categories of work. These illustrative examples let readers see WHO in action: shipping 1.5 billion doses of medicine for the neglected tropical diseases in a single year, setting up a system of nutrient profiling to serve as the evidence base for restricting the marketing of unhealthy foods and beverages to children, and sponsoring research to investigate options for improving the survival of preterm infants. Other examples show how WHO's normative and standard-setting functions translate into initiatives, often supported by partners, that bring results within countries. Each profile of programme activities is accompanied by a tabular breakdown of budget and expenditure for headquarters and the six regional offices.

The second part sets out the financial report for the biennium, including audited financial statements for 2015. More detailed information on the actual deliverables, challenges, and impediments experienced during the biennium is set out in the Programme budget web portal. During the financing dialogue introduced under WHO reform, Member States expressed their appreciation for the financial information available through the World Health Organization Programme budget web portal,[1] but also asked for more programmatic detail. Therefore, as part of my commitment to increased transparency, Member States are provided with two avenues to access the information they need.

This initial report should be viewed as a work in progress as WHO continues to implement the reforms requested by its Member States. The integration of financial and programmatic information will continue to be strengthened in future biennia, along with improvements in linking achievements in individual programme areas with outcomes and impact.

I submit this document to Member States as another instrument for holding WHO accountable for the resources invested in its work.

[1] See http://extranet.who.int/programmebudget/, accessed 4 April 2016.

OVERVIEW

Half of the 10 global impact targets[1] in the Twelfth General Programme of Work, 2014–2019, to which WHO's work contributes were aligned with the 2015 targets set for the Millennium Development Goals. Of these, the target of a 25% reduction in deaths from AIDS has been exceeded, but the 50% and 75% reductions in deaths from tuberculosis and malaria, respectively, have not yet been met. Child mortality has decreased by 53% since the statistical baseline year of 1990 and maternal mortality by 44%. Even though these figures fall short of the two thirds and three quarters declines that were targeted they are still significant achievements. One additional impact target with a 2015 deadline was the eradication of dracunculiasis[2]. While the task is not complete, there is a realistic prospect that no more new cases will be seen in three of the four remaining endemic countries. The 2015-dated impact targets will be updated so that they are aligned with Sustainable Development Goal targets when the monitoring framework is agreed.

At outcome level, which provides a more proximate measure of WHO's contribution, the picture is more mixed. In relation to HIV/AIDS, for example, one initial outcome target of getting 15 million people on treatment with antiretroviral medication has already been achieved[3]. Outcome targets for HIV/AIDS in the Programme budget 2016–2017 have therefore been revised. In many other programme areas, it is too early to assess outcome achievement. Thus, for each programme area, Part 1 of the report summarizes the achievement of outputs, and, to the extent possible, illustrates how outputs contribute to the achievement of outcomes.

In the absence of any other aggregate measure of achievement, this overview takes a different approach. It draws on the detailed reports submitted by category and programme area networks, but looks – selectively – at the work of WHO from a more macro perspective. It takes as its starting point the Twelfth General Programme of Work and assesses progress made during the first biennium of the six-year period. Specifically, it makes an assessment, predominantly in qualitative terms: (a) as to how WHO has responded to some of the global *challenges* outlined in Chapter 1 of the Twelfth General Programme of Work; (b) the extent to which WHO has fulfilled its *leadership* role in relation to the priorities highlighted in Chapter 3; and (c) the extent to which governance and managerial (and particularly financing) reforms in Chapters 4 and 5 have increased organizational effectiveness and performance.

1. RESPONDING TO A RAPIDLY CHANGING GLOBAL ENVIRONMENT

(a) New political, economic and social realities

The geography of poverty

The Twelfth General Programme of Work makes the point that while a significant proportion of the world's absolute poor live in countries that are classified as middle-income, there are still many people living in the world's most unstable and fragile countries – countries that remain dependent on external technical and financial support. To what extent has WHO's country financing mirrored that of others donors and increasingly concentrated on the poorest countries? How has WHO's work adapted to address the issues of poor or otherwise disadvantaged people in middle- and high-income countries?

- On financing, two trends are apparent. First, WHO's spending at country level has increased in absolute terms from US$ 1.7 billion in 2010–2011 to US$ 2.3 billion in 2014–2015 and in relative terms from 46% of total expenditure in 2010–2011 to 52% in 2014–2015. However, rather than reflecting a systematic shift in resources, evidence suggests that the aggregate increase is in part a function of highly-specified funding from the GAVI Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria in several countries, and expenditures on polio and emergencies and disasters in a more limited number.

[1] See the Twelfth General Programme of Work 2014–2019 annex on impact targets.

[2] See programme area 1.4, Neglected Tropical Diseases.

[3] See programme area 1.1, HIV/AIDS.

- With economic progress, what countries need and demand from WHO changes. Where support for programme implementation may have been a priority in the past, the focus shifts towards advocacy for neglected health problems and populations; strategic advice on health policy and strategy; and facilitating exchanges of experience with countries at similar levels of development. These changes have implications for staffing levels and the skill mix. A recent independent evaluation of country presence suggests that in some regions (notably the Western Pacific Region) such changes are beginning to be implemented. However, there is still no *systematic* process in place for matching country office capacities to the changing needs.

Economic uncertainty: pressure on public spending in donor countries

Many of the predictions in the Twelfth General Programme of Work of what would follow the economic and financial crisis have been borne out. The annual year-on-year increases that saw a threefold increase in development assistance for health over a period of 10 years have now ceased. What was less predictable is that already constrained aid budgets would be used to finance new priorities – notably health security – and issues of major concern to donor countries themselves, such as migration. One result is that it has been increasingly hard to fund new priorities, such as noncommunicable diseases, at country level from external resources: progress will therefore depend on domestic financing.

At the same time, many countries have enjoyed consistent economic growth and thus no longer need, or are eligible for, concessional financing. While external finance will remain important, albeit for a decreasing number of countries, WHO's work needs to respond to these trends:

- Ensuring that aid is used effectively in the 20–30 countries that are still dependent on external financial assistance is seen as increasingly important. To this end, the International Health Partnership[1] is now focusing on these countries, but also broadening its scope in order to coordinate work on universal health coverage.

- Although eligibility for external funds is based on economic trends alone, there is no guarantee that health and other social indicators will track economic growth consistently. Ensuring that such countries have continued access to affordable prices for key commodities, such as vaccines, has therefore been an important safeguard. WHO works with the GAVI Alliance to prepare transitional plans of action, which help determine continuing eligibility for GAVI prices. Countries that are no longer eligible can access advice on market prices and procurement procedures online through WHO's Price Transparency Initiative.

- The key response, however, is that WHO is increasingly becoming a vital source of information and advice on *national spending for health*. The shift in focus that started with the *World health report 2010* has now gained momentum, so that the prime concern in a growing number of programmes is less the US$ 28 billion for health in external financing and more the US$ 6.5 trillion that is spent on health largely from domestic resources.

Shifts in the relative power of the State, the private sector and civil society

The report will highlight many examples of how WHO has worked productively with both the private sector and civil society, with demonstrable benefits to people's health. Examples include the negotiation of the Pandemic Influenza Preparedness Framework, new vaccine development and recent work on road safety.

While the Twelfth General Programme of Work makes the point that it is hard to imagine significant progress on the major challenges facing the world – including health – without the involvement of the private sector and civil society, WHO's main interlocutors are still primarily national governments.

- Broadening the range of WHO's interactions with other stakeholders that influence health outcomes is an area where the views of Member States remain deeply divided. While all agree on the need to maintain and protect the integrity of WHO's normative work, progress in defining the rules of engagement with non-State actors has been much slower than anticipated.

[1] See http://www.internationalhealthpartnership.net/en/

Rapid evolution of technology

Developments in technology feature in many of the programme areas in this report. The Twelfth General Programme of Work, however, singled out the growing importance of information and communications technology, and within this area, the power of social media[1].

- At the beginning of the biennium, WHO had about 1.4 million subscribers on two social media channels. Two years later that figure had risen to more than 5.3 million with 2.7 million followers on Twitter alone. Across 11 social media channels, there are now 6.74 million subscribers, so that WHO's health messages reach millions of people – worldwide – every day.

- Innovation in the way messages are framed, targeted and disseminated has continued, notably during emergencies and outbreaks. External recognition has come for using the Twitter social media channel more effectively than any other international organization in Geneva in 2015.

(b) More complex health problems

From Millennium Development Goals to Sustainable Development Goals

The negotiation of a new set of global development goals has preoccupied the global health community for the past four years. The final result puts health in a prominent position and most of new Sustainable Development Goal priorities were anticipated in the Twelfth General Programme of Work. Moreover, several health targets follow from the unfinished Millennium Development Goal agenda and much of the critique (around feasibility, precision and measurability) that has been directed at the Sustainable Development Goals as a whole can be relatively easily countered when it comes to the health goal, even though the agenda is now more ambitious.

At the same time, it is important to recognize the breadth of the new agenda: one that sees health not only as ensuring healthy lives and promoting well-being for all at all ages, but also one in which health and its determinants influence, and are influenced by, other goals and targets as an integral part of sustainable development.

- WHO has started a dialogue about the implications of the Sustainable Development Goals for how WHO provides support to countries. The text of the declaration – *Transforming our world: the 2030 agenda for sustainable development* – provides a good starting point by placing universal health coverage as the target that underpins, and is key to the achievement of, many of the others.

  > *"To promote physical and mental health and well-being and to extend life expectancy for all, we must achieve universal health coverage and access to quality health care. No one must be left behind …"*

- A recent WHO publication[2] shows this relationship diagrammatically (see Figure 1). It further argues that achieving the new health targets cannot rely on business as usual. One of the acknowledged problems of the Millennium Development Goal era was the fragmentation of country health systems that resulted from the establishment of separate programmes, each focusing on its own targets, with little consideration for the impact on the health system as a whole.

- With 13 health targets covering most national health concerns, an approach to national health development that focuses on individual programmes in isolation will be counterproductive. There is now a growing consensus that to respond to the new agenda, individual programme areas need to contribute to, and work within, the framework of a country's overall health plan or strategy.

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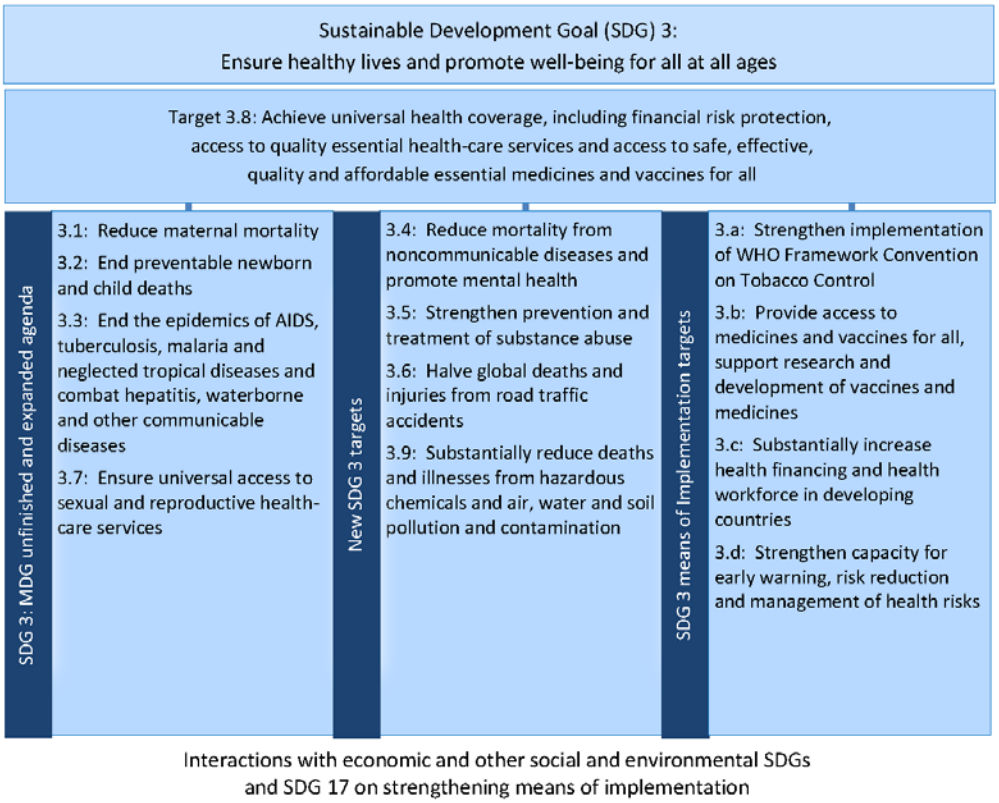
[1] See programme area 6.5, Strategic Communications.

[2] Health in 2015: from MDGs to SDGs. Geneva: World Health Organization; 2015.

Figure 1. A framework for Sustainable Development Goal 3 on good health and well-being and its targets in the 2030 Agenda for Sustainable Development



Complex problems require cross-sectoral solutions

While universal health coverage is a vehicle for bringing the health sector together, one major difference between the Sustainable Development Goals and the Millennium Development Goals is the greater focus on health problems that are not amenable to purely technical solutions and that do not fit neatly into single sectoral boxes. This is particularly true of the noncommunicable disease agenda, which is discussed in more detail under the leadership priorities below. However, two of the most pressing cross-sectoral issues facing global health received little attention in the United Nations General Assembly declaration on the Sustainable Development Goals, adopted in resolution 70/1.[1] Antimicrobial resistance appears, almost as an afterthought in the health paragraph of the declaration, but is absent from the targets. Similarly, the health challenges of ageing populations appear only in Goal 2 on nutrition and Goal 11 on cities (safer environments) and are absent from the section on health.

- By contrast, both healthy ageing and antimicrobial resistance have emerged as strong priorities for WHO over the last two years.

- The *World report on ageing and health* [2]has focused attention on the importance of maintaining functional ability as the key measure of successful ageing. The report stresses the importance of linkages between health, employment and pensions policy as well as health and social care. The

[1] Transforming our world: the 2030 Agenda for Sustainable Development, see http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/70/1 (accessed 7 April 2016).

[2] See programme area 3.2, Ageing and health.

strategies developed in the report will now form the basis of a new global strategy and action plan on ageing and health, to be considered for adoption by the Sixty-ninth World Health Assembly in 2016.[1]

- Since being highlighted as a concern in the Twelfth General Programme of Work, WHO has led the debate on antimicrobial resistance with partners in other sectors, notably FAO and OIE. A global action plan on antimicrobial resistance was adopted by the Health Assembly in 2015;[2] antimicrobial resistance was one of the three health issues in the communiqué of the 2015 G7 meeting; a joint (WHO, FAO, OIE) document has been prepared to guide the development of national plans; and plans are now in hand to bring antimicrobial resistance to the United Nations General Assembly in 2016.

A greater focus on the means by which better outcomes are achieved

The Millennium Development Goals focused largely on aggregate outcomes. With the growing complexity of the agenda comes the need for a greater focus on the means by which outcomes are achieved. It was for this reason that the Twelfth General Programme of Work put much greater emphasis on health systems strengthening (discussed in more detail in the section on leadership priorities) and the enduring values that underpin WHO's work.

- Mainstreaming gender, equity and human rights[3] continues to guide WHO's work in all programme areas. WHO has committed to implementing the United Nations System-wide Action Plan to further the goals of gender equality and women's empowerment both within the Organization itself and within the policies and programmes that WHO supports. For example, given the preponderance of women in the health workforce worldwide, gender issues featured strongly in the 2014 follow-up to the Recife Political Declaration on Human Resources for Health and the subsequent global strategy on human resources for health to 2030 that will be submitted to the World Health Assembly in 2016.

- Disaggregated data from the Global Health Observatory[4] help monitor progress towards greater health equity. All three elements – gender, equity and rights – will remain core concerns as the world turns its attention to the Sustainable Development Goals and the notion that no one should be left behind.

(c) Health and humanitarian action

A great deal has been said and written about WHO's and the world's response to Ebola, which will not be repeated here. Rather, the aim is to highlight factors that will influence WHO's performance in the face of future crises.

One major lesson stands out. In the section on future challenges, the Twelfth General Programme of Work points to the link between health security and humanitarian action. And it is this link, or more precisely, the failure to make the link sufficiently quickly or effectively, that stands out as one of the major lessons learnt from the crisis.

Pandemic influenza and severe acute respiratory syndrome were primarily *health* crises. While they had major economic impacts, with only a few exceptions they did not cause major humanitarian disasters. Concurrent with the outbreak of Ebola was the emergency in the Syrian Arab Republic and acute or chronic conflict affecting several other countries. These are predominantly *humanitarian* crises. They have a major impact on people's health, certainly, but health is an integral part of the response rather than being in a leadership role.

- In 2014, however, as soon as Ebola reached the cities of West Africa, it was simultaneously a health *and* humanitarian crisis, but treated primarily as the former. The failure to bring in the assets of the humanitarian sector, and to recognize the need for a global response at the highest levels of

[1] Document A69/17.

[2] See resolution WHA68.7.

[3] See programme area 3.3 Gender , equity and human rights mainstreaming.

[4] See http://www.who.int/gho/en/

government in the affected countries and beyond, and the focus on Ebola as primarily a health issue – with WHO using its routine processes and procedures – underpins many of the critical commentaries that have followed in the aftermath of the crisis. By contrast, when WHO exploited its traditional strengths in convening the best in the scientific world to produce diagnostics and vaccines with extraordinary speed, its success has been widely applauded[1].

- The need to make WHO more effective as a humanitarian actor underpins the current proposals for reform. It is agreed that WHO does not need to do everything, neither is there a need for a stand-alone organization. Rather the imperative is that WHO has substantive and institutionalized links with other major humanitarian players in the United Nations and the wider international system.

- In addition, however, in the face of future emergencies, WHO requires systems and procedures that allow for a rapid and coherent response, with the clear lines of command and control that are needed to ensure the rapid deployment of human, financial and material resources[2]. Some have therefore argued for an autonomous "organization within an organization" that can take over completely in the face of any crisis. However, it is likely that a more nuanced approach is needed: one that more explicitly recognizes the assets that different levels of WHO can bring to the situation, and one that more clearly defines the boundaries and limits of "emergency authority" in different kinds of crises, notably in countries facing chronic humanitarian emergencies.

Financial lessons from Ebola

In 2015, WHO spent US$ 240 million on the Ebola response, in addition to the US$ 72 million incurred in 2014. Lessons learnt from this crisis are now being used as part of a review of WHO's capacities to respond to future large-scale health emergencies. In some offices, failure to understand established procedures contributed to implementation delays, and/or an increased level of operational risk. A more fundamental lesson (which was already apparent following the H1N1 pandemic) was the need for the Organization to have a source of flexible funding for rapid disbursement at the beginning of any crisis. Having rejected a similar proposal in 2011, WHO's Governing Bodies agreed to the establishment of a new Contingency Fund for Emergencies (decision WHA68(10)). With a target of US$ 100 million, several contributions have been promised however the current balance of fund available and pledges were US$ 25 million[3].

(d) New challenges in health governance

The Twelfth General Programme of Work summarized key challenges in health governance in the following way:

> *"A growing number of health-related issues where agreement requires careful negotiation in order to balance technical and political interests; … [a] wider range of actors involved in global health challenges the coordinating and directing authority of WHO; … [and] a growing interest in ensuring that that governance in other sectors and policy arenas avoids compromising health, and ideally, has a positive impact on it."*

These challenges have been manifest throughout the biennium: through negotiation in the Health Assembly of a range of new global strategies; in debates on reforming the "global health architecture"; and in the formulation and negotiation of the Sustainable Development Goals.

- The last two years have seen resolutions in a number of key areas. Strategies for tuberculosis, hepatitis, malaria and the Every Newborn Action Plan[4] have been important in their own right, but also as a means of setting new post-2015 targets ready for incorporation into the monitoring framework for the Sustainable Development Goals and universal health coverage.

[1] See programme area 1.5 Vaccine-preventable diseases.

[2] See programme area 5.6 Outbreak and crisis response.

[3] See http://www.who.int/about/who_reform/emergency-capacities/contingency-fund/en/.

[4] See programme area 3.1 Reproductive, maternal , newborn, child and adolescent health.

- The four separate resolutions relating to different aspects of integrated people-centred health services have provided a solid underpinning for the approach to service delivery as part of universal health coverage. Work during the biennium on a new global strategy on the health workforce to 2030[1], rather than focusing exclusively on countries facing major shortages in isolation, takes a genuinely global and multisectoral perspective, seeing health workforce issues more in terms of worldwide labour market dynamics, and as an issue of critical concern for gender equity. This approach has now set the scene for a new time-limited United Nations High-Level Commission on Health Employment and Economic Growth appointed by the United Nations Secretary-General and chaired by the Heads of State of France and South Africa. Following the example of earlier efforts in the field of noncommunicable diseases, this Commission is a further example of how WHO has taken what was previously seen as an exclusively a health issue and elevated it to an issue of foreign policy, of concern to the highest levels of government.

- Much of the world's attention has recently been focused on structures and systems for strengthening health security. However, reducing fragmentation and duplication of effort in the health sector more generally – particularly in countries with large numbers of development partners – remains a major concern to many Member States. Indeed, the idea of a single plan, a single budget and a single system for monitoring and evaluation remains far from being realized in many of the countries where it is most badly needed. At the global level, initiatives such as the UNAIDS and Lancet Commission: Defeating AIDS — Advancing global health, in which WHO played a part, have helped specify key challenges, but their impact on organizational behaviour has been limited. The launch of the Global Financing Facility[2] in 2015, which seeks to use external funding to leverage domestic resources for reproductive, maternal, newborn and child health, has the potential (with the added support of the Partnership for Maternal, Newborn and Child Health) to bring greater coherence to an area with many disparate partners. However, it fails to address the need for sector policies and strategies that cover all programmes rather than a selected subset. The International Health Partnership continues its work in a limited number of countries, and (as noted above) will increasingly focus on those in the most difficult circumstances.

- For many health professionals, health diplomacy is a new skill. Similarly, for those in the diplomatic service who negotiate on behalf of their countries, it is important to understand the specificities of the health sector. A growing area of work has therefore been in health diplomacy training – which is now obligatory for all WHO representatives. At regional level (for example in the Eastern Mediterranean Region) and at country level (for example in China) WHO now runs courses for senior officials taking part in WHO governance meetings and health-related meetings at the United Nations.

- Governance for health – an advocacy and public policy function that seeks to influence governance in other sectors in ways that have a positive influence on health – has become an increasing part of WHO's work. The overarching concern of the last two years has been to secure the place of health in the Sustainable Development Goals. As noted above, the outcome has been positive and most of the issues identified in the Twelfth General Programme of Work have found their place in the new generation of goals and targets. Moreover, the interdependent way in which the goals are organized gives added legitimacy to WHO's role in advocating for greater attention to health issues.

- While WHO is an increasingly active player in major global processes that have an impact on health, given the number of competing voices it is inevitably difficult to provide conclusive evidence of WHO's influence. Nevertheless, to take one example, detailed briefings for WHO Regional Directors helped regional and country office staff to use their good offices to inform Member State governments about the potential impact on access to medicines[3] of the Trans-Pacific Partnership, a plurilateral trade agreement. The final text suggests that developing countries achieved a significant number of their stated goals. Similarly, at the 21st session of the Conference of the Parties to the

[1] See programme area 4.2 Integrated people-centred health services.

[2] See http://www.who.int/pmnch/gff/en/, accessed 7 April 2016.

[3] See programme area 4.3, Access to medicines and health technologies and strengthening regulatory capacity.

United Nations Framework Convention on Climate Change the aim was to show the many ways in which an environmental agreement has positive health outcomes (through, for example sustainable transport and reducing air pollution[1]). While individual sectors are not mentioned, it is significant that the outcome document justifies approaches to climate change in terms of the right to health.

- In the Communiqué from the German Presidency of the 2015 G7 meeting, a specific health section focused not just on Ebola and health security, but also antimicrobial resistance, research and development for neglected tropical diseases, and efforts to end preventable child deaths and improve maternal health worldwide. An initiative – Healthy Systems, Healthy Lives – will be further taken up by the 2016 Japanese G7 presidency.

- While much health-related diplomacy takes place at the global level, regional agreements are becoming increasingly important. The recent agreement reached jointly by the Regional Office for South-East Asia and the Regional Office for the Western Pacific with the Association of Southeast Asian Nations (for the period 2014–2017) commits both parties to collaborate on a range of areas linked to WHO leadership priorities including: emerging infectious diseases, healthy borders, antimicrobial resistance, access to medicines and technologies and social determinants of health.

[1] See programme area 3.5, Health and the environment.

2. WHO LEADERSHIP PRIORITIES

The six leadership priorities in the Twelfth General Programme of Work give focus and direction to WHO's work. They were selected in order to highlight areas in which WHO's advocacy and technical leadership have the potential to shape the global debate, to secure country involvement and to drive the way the Organization works – integrating efforts across and between levels of WHO. This section comments briefly on each of the priorities in these terms. For more detail on the specific programmatic components of the leadership priorities please see the major highlights by programme area in section 1 of the report.

(a) Advancing universal health coverage

Following the groundwork laid by the *World health report 2010*, the uptake of universal health coverage as a unifying health sector strategy by a growing number of countries owes much to WHO. Similarly, the inclusion of universal health coverage as a target within Goal 3 of the Sustainable Development Goals was a reflection of a groundswell of support for this concept on the part of large number of governments and, significantly, from a large number of civil society groups.

While progress to date has been encouraging, it is appropriate that universal health coverage remains a WHO leadership priority in the coming years. Much has yet to be done, and several controversies still need to be resolved.

- Universal health coverage is relevant to countries at all stages of development. At a conceptual level its components are clear in terms of progressive realization of universal access to all necessary services and protection from adverse financial consequences. The development of universal health coverage in practice, however, also has an important regional dimension. With its multiplicity of financing and delivery systems the European Region, for example, provides a wealth of comparative experience on which other regions can draw. In the Americas, universal health coverage is seen as a highly political issue and in many countries as a means of decreasing growing inequalities. In other parts of the world, particularly in the Eastern Mediterranean Region, where many countries are trapped in chronic emergencies, universal health coverage is held as an aspiration that a better future is possible. It is likely that elements of such "regional DNA" will continue to shape future developments and WHO will use its regional structures to adapt global guidance to the prevailing contexts.

- A major challenge in convincing some of the more sceptical countries of the value of universal health coverage in the negotiations of the Sustainable Development Goals was to show that progress towards universal health coverage can be measured. A framework with a limited number of indicators for monitoring access to services and financial protection, developed collaboratively by WHO and the World Bank, has been a significant achievement during the biennium. However, there remains work to be done to ensure that the metrics used for Sustainable Development Goal monitoring fully reflect those that were agreed for universal health coverage – particularly in the area of financial protection.

- A further area of controversy concerns the extent to which universal health coverage represents a unifying concept for the achievement of health targets in the Sustainable Development Goals. While the WHO definition of universal health coverage includes access to services that address the social determinants of health, there are many who see universal health coverage as primarily a strategy for the health sector and for health services. As countries start to articulate strategies for achieving the new goals, this is an area where greater clarity will be needed. It may well be that universal health coverage represents *one* unifying concept, as suggested in Figure 1 above. However, given the growing importance of governance for health (or Health in All Policies[1]), universal health coverage alone is not sufficient to capture the breadth of the new Sustainable Development Goal agenda.

[1] See programme area 3.4 Social determinants of health.

- To date the major focus on the financing side of universal health coverage has been on financial protection, with a particular focus in many low-income countries on reducing the potentially impoverishing burden of out-of-pocket payments. While this work continues to be essential, it needs to be complemented by work to increase the efficiency and effectiveness of domestic spending through paying greater attention to how financial incentives (linked to the achievement of results) can be used to increase performance.

(b) Health-related Millennium Development Goals: the unfinished agenda and future challenges

The unfinished agenda of the Millennium Development Goals was included as a leadership priority for several reasons. First, because countries at all levels of income insisted that the debate about a new generation of development goals should not undermine ongoing work. Moreover, it was important that the lessons of the Millennium Development Goals informed how the Sustainable Development Goals were formulated. Secondly, taken together with neglected tropical diseases and polio eradication, the programmes covered as part of this priority represent one of the main ways in which WHO's work contributes to poverty reduction. Thirdly, the Millennium Development Goal agenda – in the words of the Twelfth General Programme of Work – "integrates work across the Organization, bringing together under a single priority several aspects of WHO's work, particularly the need to build robust health systems and effective health institutions …"

- The first reason for the Millennium Development Goal agenda being a priority has clearly, and without any great difficulty, been realized – the Sustainable Development Goals continue the legacy of their predecessors and increase the ambition of the health targets. In addition, neglected tropical diseases[1] have now found their place in the Sustainable Development Goal agenda. Polio eradication is not specifically mentioned but is implicitly included under Target 3.3 on communicable diseases[2].

- There has also been growing recognition that neglected tropical diseases can no longer be neglected, in part because of their potential impact on health security, but equally because they are a manifestation of absolute poverty and an obstacle to any reasonable conception of what constitutes sustainable development.

- The third element – the Millennium Development Goal agenda as an integrating force in WHO – merits further reflection. There are positive signs, such as the agreement on a Global Reference List of 100 Core Health Indicators[3]. However, the indicator list, which provides concise information on the health situation and trends, goes well beyond the Millennium Development Goals and includes noncommunicable disease risk factors, as well as measures of health system effectiveness. Furthermore, in their respective documentation, including in global strategies, all WHO Millennium Development Goal-related programmes now make reference to their role as essential elements of universal health coverage.

- While some of WHO's major donors identify the unfinished Millennium Development Goal agenda as a priority for providing funding support to WHO, there are several questions to consider in terms of this leadership priority. Does it fulfil its original purpose in terms of organizational integration? Would universal health coverage now provide an equally effective or possibly more powerful and relevant integrative structure? Given the current budgetary and planning structure, which sees every programme as a separate and potentially competing budget centre, what other measures are needed to promote greater programme integration?

[1] See programme area 1.4 Neglected tropical diseases.

[2] See figure 1 A framework for Sustainable Development Goal 3 on good health and well-being and its targets in the 2030 Agenda for Sustainable Development.

[3] See programme area 4.4, Health systems, information and evidence.

(c) Addressing the challenge of noncommunicable diseases, mental health, violence, injuries and disabilities

The noncommunicable disease leadership priority is coterminous with Category 2 in the Programme budget structure and covers the five programme areas that fall within Category 2. It was selected as a leadership priority primarily due to the devastating social and economic impact that will result if noncommunicable diseases are not addressed more effectively.

- There is no doubt that WHO has played a major role in elevating the importance of the noncommunicable disease agenda globally and regionally. From a situation of denial and failure to recognize noncommunicable diseases as a significant problem at the beginning of this decade, particularly in many low-income countries, the noncommunicable disease agenda is now at the forefront of the global health agenda, and noncommunicable diseases have a clear place among the Sustainable Development Goal targets[1].

- The key leadership strategy has been to bring the challenge of noncommunicable diseases to the attention of Heads of State and government at the United Nations. Two successive high-level meetings of the United Nations General Assembly have increased awareness among a politically powerful audience and, significantly, resulted in a series of time-bound commitments in relation to national targets, multisectoral actions plans, risk reduction through noncommunicable disease best buys, and more effective health systems.

- Engagement of the United Nations General Assembly has been used for road safety[2], nutrition[3] and disability in recent years. However, it has been more difficult to find sponsors who will take up the issue at a high level for mental health, although the specific but growing problems of dementia and autism spectrum disorders have received attention.

- With greater awareness has come a growing demand from countries for technical support, which WHO alone has not been able to adequately fulfil. The new United Nations Interagency Task Force on the Prevention and Control of Noncommunicable Diseases helps by providing a global coordination mechanism for United Nations partners that can contribute to the response at country level. But progress in working together in practice is hampered at country level when other United Nations agencies do not have budget lines for working on what is perceived as primarily a health problem.

- The challenge of noncommunicable diseases is a challenge of health governance. However, at the global level, Member States remain deeply divided when it comes to engagement with the private sector. At country level there has been significant progress in relation to action against tobacco. The use of additional levies on sales was recognized as a resource mobilization strategy for governments at the United Nations Conference on Financing for Development in 2015.

- Progress in other areas at country level has been slow. The recent dialogue on the role of international cooperation in the prevention and control of noncommunicable diseases showed that there is little appetite among major development agencies to make significant aid funding available. Progress will therefore depend on domestic resources. At the same time, however, while many countries have drafted ambitious multisectoral action plans, many governments are still failing to take a leadership role in creating the necessary policy and institutional environment for cross-sectoral action, relying still on inadequately resourced noncommunicable disease departments in ministries of health.

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[1] See programme area 2.1, Noncommunicable diseases.

[2] See programme area 2.3, Violence and injuries.

[3] See programme area 2.5, Nutrition.

- In the face of these challenges it is appropriate that noncommunicable diseases remain a WHO leadership priority. Promising new directions include the selection of 12 fast-track countries to show more rapid progress against targets to be reviewed at the United Nations General Assembly in 2018; and increasing attention to working with city administrations – given the importance of rapid urbanization in the causal chain underpinning noncommunicable diseases. Within WHO the challenge remains of increasing collaboration among the programmes that make up Category 2 and closer cooperation with health systems departments at headquarters and in regional offices to ensure that health systems strengthening takes better account of the attributes systems need for better noncommunicable disease prevention and control.

(d) Implementing the provisions of the International Health Regulations (2005)

The 2011 report of the Review Committee on the Functioning of the International Health Regulations (2005) on the H1N1 (2009) pandemic concluded that the world is ill-prepared to respond to a severe pandemic or to any similar global, sustained public health emergency. The case for focusing on implementation of the provisions of the International Health Regulations (2005) was thus a logical choice as a leadership priority at the time of drafting the Twelfth General Programme of Work. Subsequent events have highlighted the vital importance of the Regulations, but equally they have exposed weaknesses in compliance by Member States with a legally binding document and weaknesses in the approach to implementing the Regulations[1].

- The report of the Ebola Interim Assessment Panel provides a succinct summary: "The Ebola crisis again highlighted the shortcomings of this instrument and its application by States and the WHO Secretariat as it now stands: (i) Member States have largely failed to implement the core capacities, particularly under surveillance and data collection, which are required under the International Health Regulations(2005), (ii) in violation of the Regulations, nearly a quarter of WHO's Member States instituted travel bans and other additional measures not called for by WHO, which significantly interfered with international travel, causing negative political, economic and social consequences for the affected countries; and (iii) significant and unjustifiable delays occurred in the declaration of a Public Health Emergency of International Concern (PHEIC) by WHO[2]".

- The focus of WHO's work in the past has been on capacity building, often with inadequate resources, with responsibility for reporting based on self-assessment by countries[3]. It is now proposed that the whole approach to capacity building be strengthened through a new alliance being forged with the Global Health Security Initiative. The new alliance will carry out joint assessments of a broader range of capacities, raise resources for countries and institute a more rigorous approach to reporting.

- Prior to the health crises experienced in the last two years, work on the provisions of the International Health Regulations (2005) at country level had been carried out in isolation from work on health systems strengthening. Recent experience has brought home that such an approach is no longer tenable. "Most least developed and developing countries with poorly performing health systems are highly vulnerable and ill-equipped to respond to natural disasters, political, social and economic crises and conflicts, epidemics, pollution and other threats."[4] Building resilient health systems is thus a good in its own right and a critical element of strengthening global and national health security.

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[1] See http://www.who.int/ihr/about/en/.

[2] See http://www.who.int/about/who_reform/emergency-capacities/en/.

[3] See programme area 5.1, Alert and response capacities.

[4] *Health systems for universal health coverage and health security: a country and global agenda*. Document prepared for the G7 Health Experts' Meeting 18–19 February, Tokyo, Japan.

- While capacity building remains a necessary component of making the Regulations more effective, it is far from sufficient. It is evident that more effort is needed to ensure that countries comply with their responsibilities under the International Health Regulations (2005) . The Interim Report makes a series of relevant recommendations, including the need to explore financing mechanisms (for example through insurance) to mitigate adverse economic impacts and to provide real incentives for timely notification of public health risks. It also notes the potential for disincentives to discourage countries from taking measures that interfere with trade or the provision of material assistance to affected countries.

- Lastly, the International Health Regulations (2005) are well recognized in the health community but less beyond. In line with what was discussed above about the link between health and humanitarian action, it is critical for conformity with the Regulations to be a concern for humanitarian organizations as well.

(e) Increasing access to essential high-quality, effective and affordable medical products

Equity in public health depends on access to essential, high-quality and affordable medical technologies, medicines, vaccines and diagnostics. As an area in which WHO has traditionally had a comparative advantage, access to medical products was included in the Twelfth General Programme of Work as one of the more specific leadership priorities. Work is centred in the Department of Essential Medicines and Health Products at headquarters and its equivalents in regional offices, but also draws on policy development for vaccines. In addition, several programme areas include increasing access to medicines and diagnostics among their outputs.

- Access to essential medicines and vaccines is now explicitly recognized as a key element of universal health coverage under Target 3.8 of the Sustainable Development Goals.

- WHO's work focuses on the specification, development and testing of *products* (medicines, vaccines, diagnostics and other technologies) and *processes* – such as the definition of essential medicines lists, good manufacturing practices, prequalification and capacity building for regulatory functions – that help increase access.

- On the product side, a key focus has been the list produced by the United Nations Commission on Life-Saving Commodities for Women and Children. WHO has also worked with UNITAID and other partners to develop a new fixed-dose combination for children with TB[1], which can now be accessed by countries through the Global Drug Facility. While there has been substantial investment by donors to make the life-saving commodities more widely available, there is as yet no consolidated data that tracks changes in access.

- Much of WHO's normative work on products faces a similar challenge. While there is a demand for more International Nonproprietary Names, more standards for biologicals and pharmaceuticals, and more products, the challenge remains to show that the net effect of this work is to increase access.

- At the same time, it is important to recognize that the theory of change that underpins WHO's normative work in this area has more than one component. One is the direct line between product development and increased access in the field. In addition, however, inclusion of a new medicine in the essential drug list (revised in 2015) or prequalification of a medicine or vaccine can have additional impacts on price, on manufacturing capacity in producing countries, and on the purchasing policies of major donors. Capturing these "network effects" of WHO's normative work, which are often overlooked in the multilateral aid reviews conducted by several donors, is critical not just in the field of medicines but in many other areas (notably treatment guidelines).

[1] See programme area 1.2, Tuberculosis.

- Recent achievements show that it is possible to jump-start technological development in the face of a global threat. At the onset of the epidemic, Ebola vaccine had never been tested in humans. By July 2015 – a year and a half later – preliminary results were published showing that it was possible to control the disease by a vaccine. The story of Ebola vaccine development is told in full in section 1 of the report. In addition to work on vaccines, the prequalification programme assessed 16 diagnostic tests for use in the field, one of which was found to be of adequate quality. There are many diseases with the potential to trigger chaos and human suffering. The lessons learnt from Ebola have now been captured as part of the research and development blueprint for action to prevent epidemics.

- While it is not the only issue affecting access, price remains a pressing concern for national authorities and others paying for medicines. Price monitoring has recommenced in a number of countries and information technology-based solutions are being developed to enhance monitoring capacity. While the focus in the past has been the cost of medicines for communicable diseases, particularly HIVAIDS, the cost of medicines (and indeed vaccines) for noncommunicable diseases is now becoming a growing focus of attention.

- In early 2016, the United Nations Secretary-General Ban Ki-moon convened a High-Level Panel on Access to Medicines. The proposed objective of the Panel is "to review and assess proposals and recommend solutions for remedying the policy incoherence between the justifiable rights of inventors, international human rights law, trade rules and public health in the context of health technologies". It is intended that it will complement and broaden the scope of the work carried out by WHO under the auspices of the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property, which focused primarily on Type 2 and Type 3 diseases that mainly affect low-income countries.

(f) Addressing the social, economic and environmental determinants of health as a means of reducing health inequities within and between countries

The Twelfth General Programme of Work noted that work on the social, economic and environmental determinants of health is not new and that its origins could be traced to the Alma Ata Declaration on Primary Health Care. Over time the work on social determinants has been given renewed emphasis – through the movement on Health in All Policies, through the conceptualization of health promotion in terms of policies in other sectors that promote good health, through the notion of "governance for health", and through the influential work of the Commission on Social Determinants and the follow-up World Conference on Social Determinants of Health held in Brazil in 2011 that linked the idea of determinants with the achievement of health equity.

- The fact is that WHO – at different levels and in different parts of the Organization – has an extensive portfolio of work that reflects this leadership priority. This overview has touched on many of these already. For example: much of the work on noncommunicable disease risk factors deals with a wide range of economic, social and political determinants; WHO's work on HIV/AIDS and TB is deeply influenced by concerns for the social and economic constraints that exclude groups in a population from accessing care and treatment. Work on the links between health and climate change and health and air pollution shows how environmental determinants influence health outcomes[1]. Access to essential medicines is influenced by trade agreements and the economics of local production – both of which are subjects of WHO work. Addressing acute shortages in the health workforce involves dealing with the politics of labour markets and migration. Universality in health coverage has to address the problems of those who lack citizenship. Health is the first casualty of civil conflict, and the countries whose economies are hardest hit in the event of outbreaks or epidemics are inevitably the poorest.

[1] See programme area 3.5, Health and the environment.

- The breadth of this agenda raises interesting questions. In terms of assessing WHO's performance, using a theory of change that examines the contribution that work on determinants makes to the achievement of outcomes in each programme area will probably say more than the single impact goal in the Twelfth General Programme of Work, which is currently framed in terms of reducing urban–rural differentials in under-five mortality.

- Secondly, the range of work under this heading raises questions about the role of a specific programme area – which currently works on a limited range of substantive issues – primarily environmental determinants in relation to housing and slum settlements – and, separately from other programmes

- Work on the determinants of health was vigorously supported as a priority at the time of drafting the Twelfth General Programme of Work. This raises a third question as to whether work on determinants still needs to be seen as a separate priority or whether it is an integral aspect of the way that WHO addresses health and health equity. A future performance assessment could help to answer this question by capturing more systematically the range and effectiveness of WHO's work on the determinants of health.

3. GOVERNANCE, FINANCING AND MANAGEMENT

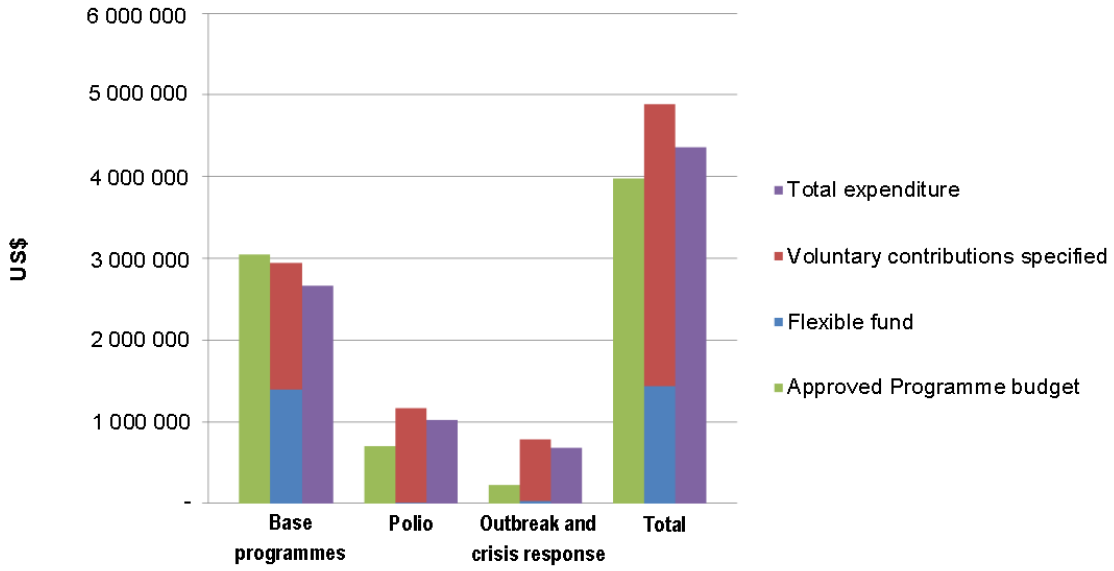
The Twelfth General Programme of Work outlined a series of health governance challenges in its Chapter 4, which have been covered in earlier parts of this overview, including WHO's relationships with non-State actors. At the time of drafting this report, negotiations continue on streamlining the way Member States govern the Organization.

This section therefore focuses firstly on an overview of WHO's financing during the first two years of the Twelfth General Programme of Work period, noting for instance how the financing trends anticipated in the Twelfth General Programme of Work have been realized in practice. Secondly, it highlights a series of complementary actions that have underpinned management improvements during 2014–2015. These have focused on measures to increase efficiency and a collective strengthening of transparency, accountability and compliance.

(a) Financing overview

Funds available for the biennium were US$ 4882 million and hence exceeded the Health Assembly-approved budget of US$ 3997 million. The higher funds available were entirely due to the two emergency segments of the WHO budget: the Global Polio Eradication Initiative and the Outbreak and crisis response segment, which between them had US$ 1943 million of funds available. The base Programme budget segment, with a budget of US$ 3049 million (categories 1 to 6, excluding Polio and Outbreak and crisis response), was financed to a level of US$ 2939 million (96%).

Programme budget 2014–2015 Financing and Expenditure (all figures in US$)



Of the available funds, 29% were flexible, with the remainder specified for Programme budget funding. Flexible funds are comprise assessed contributions, the core voluntary contributions account and administrative support revenue. The flexible voluntary contributions remain relatively low but stable between bienniums.

Contributors of core voluntary contributions (US$ million)

	Total 2015	Total 2014	Total 2014–2015
Australia	18.55	15.67	34.22
Belgium	9.92	9.92	19.84
Denmark	5.30	5.12	10.42
Finland	7.52	5.96	13.48
France	2.34	1.91	4.25
Ireland	1.54	1.09	2.63
Kuwait	0.72		0.72
Luxembourg	2.21	1.94	4.15
Monaco	0.04	0.03	0.07
Netherlands	5.98	5.98	11.96
Norway	9.17	5.59	14.76
Spain	0.81		0.81
Sweden	24.42	23.93	48.35
Switzerland	3.33	3.59	6.91
United Kingdom of Great Britain and Northern Ireland	24.25	21.90	46.14
Kurozumi Medical Foundation	0.01		0.01
Estate Of The Late John Mcinnes	0.18		0.18
Finance revenue – core voluntary contributions	**116.29**	**102.62**	**218.91**

The base segment of the Programme budget (representing 47% of the Programme budget), relies heavily on flexible financing and was the only budget segment that was not fully financed. The amount of core voluntary contribution funding available, including carry-forward, remained relatively low at US$ 247 million for 2014–2015. Available core voluntary contributions were US$ 262 million for 2012–2013. However, the pooling of all types of flexible funds and in particular their more strategic application across the biennium, based on implementation, has allowed for greater alignment of funds across programmes and major offices.

The total expenditure in 2014–2015 was US$ 4357 million, giving a balance of US$ 525 million when compared with available funds. This surplus is mostly represented by specified voluntary contributions, which will be carried forward to 2016–2017. Adding the voluntary funds already earmarked for 2016–2017 of US$ 1.7 billion brings the total funding available at the start of the 2016–2017 biennium to US$ 2.2 billion. The fully funded Programme budget 2014–2015 and the overall positive outlook for 2016–2017 bear testimony to the results of the WHO reform with the emphasis on moving from aspirational to realistic budgets, though some challenges may continue concerning funding for parts of the base segment due to limited flexible funds.

Funds available in 2014–2015 comprise the amount carried forward from the prior biennium, and the revenue received in 2014–2015. The table below provides an overview of WHO's revenue and expenditure both for the WHO Programme budget and for those funds managed outside the Programme budget.

Financial overview – all funds, 2015 and 2014 (US$ million)

	Total 2015	Total 2014	Total 2014–2015	Total 2012–2013
Assessed contributions	463	492	955	950
Voluntary contributions – programme budget	1 837	2 002	3 839	3 469
Total contributions – programme budget	**2 300**	**2 494**	**4 794**	**4 419**
Non-programme budget revenue	45	78	**123**	319
Voluntary contributions in-kind and in-service	130	50	**180**	110
Total revenue (all sources)	**2 475**	**2 622**	**5 097**	**4 848**
Expenses – programme budget	2 466	1 891	4 357	3 729
Expenses – in-kind and in-service	126	49	175	84
Expenses – non-progamme budget	147	376	523	513
Total expenses (all sources)	**2 739**	**2 316**	**5 055**	**4 326**
Finance revenue	**21**	**7**	**28**	**44**
Net	**(243)**	**313**	**70**	**566**

(b) Revenue

Total revenue for the Programme budget 2014–2015 was US$ 4794 million, comprising assessed contributions from Member States of US$ 955 million[1] and voluntary contributions of US$ 3839 million. Non-Programme budget revenue was US$ 123 million in 2014–2015, which is a decrease from the prior biennium and follows the closure or departure of several partnerships. Voluntary contributions in-kind and in-service represent donations of medical supplies, office rentals and staff costs. A full list of all voluntary contributions, by donor and by fund, is available on the WHO programme budget web portal.

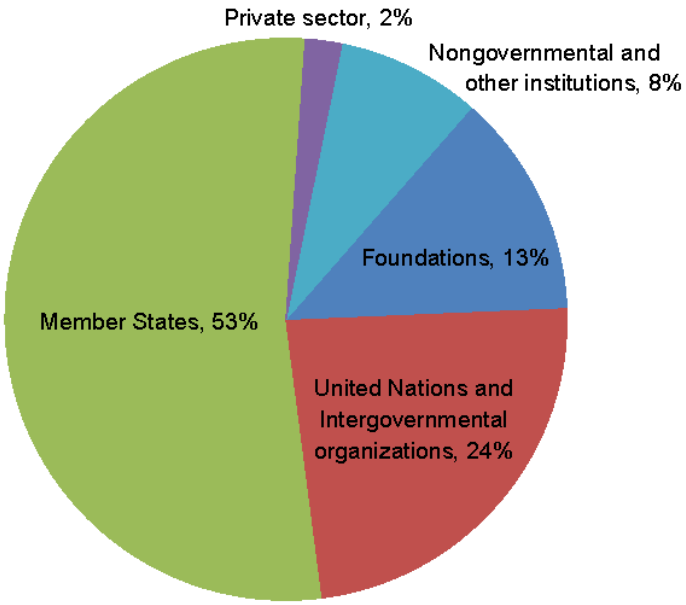
Voluntary contribution revenue increased by 11% from 2012–2013 to 2014–2015. The main increase was under the Outbreak and crisis response segment, notably Ebola-related. Contributions to base programmes remained relatively stable.

Flexible voluntary contributions decreased by 7% from 2012–2013 to 2014–2015, while specified voluntary contributions increased by 12% over the same period. Many of the specified voluntary contributions were highly earmarked and related to individual projects with differing reporting requirements within the framework of the planned results of the Programme budget.

Member States continue to be the largest source of voluntary contributions, contributing 53% of the total non-assessed (voluntary) contributions. The relative percentages are similar to the previous biennium, with the largest change being a decrease in foundations due to a reduction in certain contributions to the Global Polio Eradication Initiative.

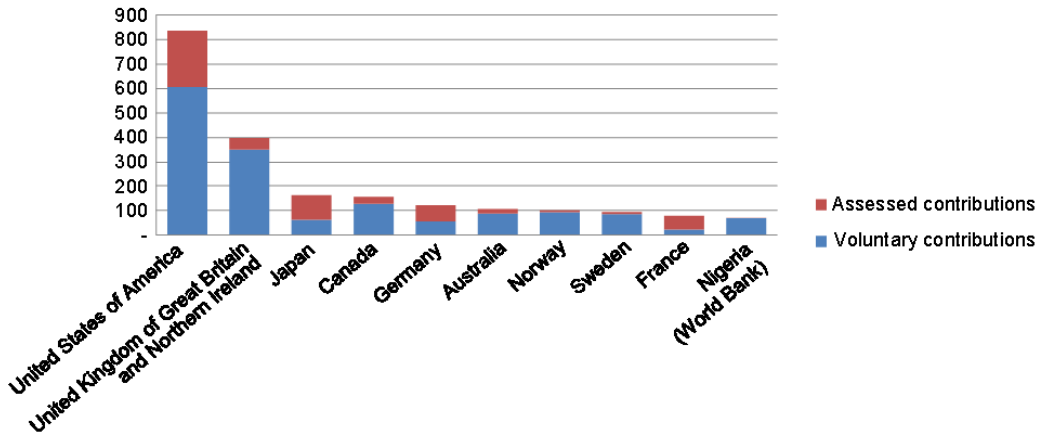
[1] The assessed contribution revenue of US$ 955 million for 2014–2015 includes amounts invoiced for the tax equalization fund. The funds available for the Programme budget 2014–2015 remain at US$ 929 million.

Revenue from voluntary contributions for 2014–2015, by source



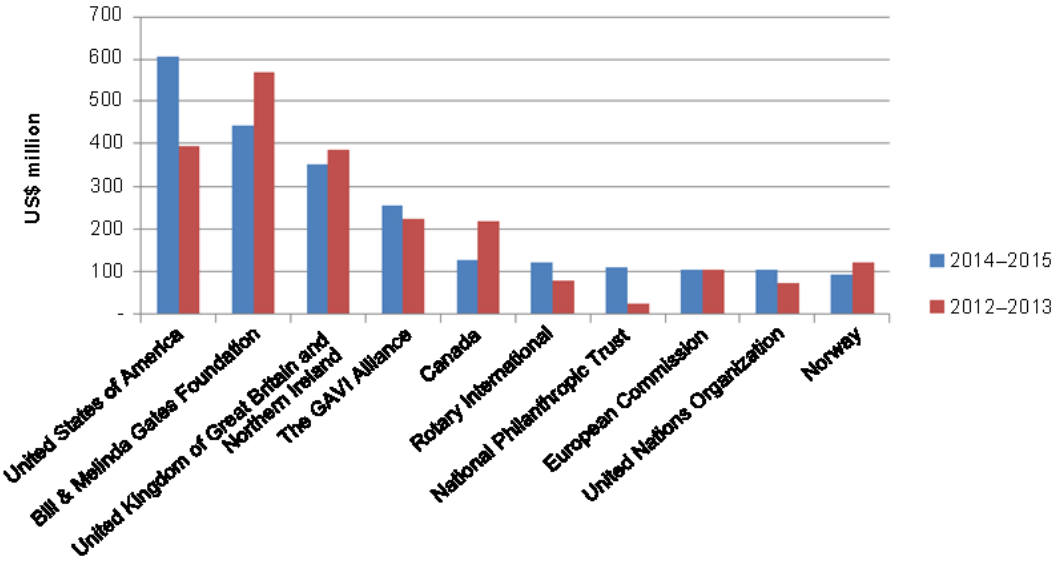
Total contributions by Member States to the Programme budget (voluntary contributions and assessed contributions) for 2014–2015 were US$ 3000 million compared to US$ 2743 million for 2012–2013. For 2014–2015, this represents 63% of total voluntary and assessed contributions. The 10 largest contributors among Member States to the Programme budget are shown below and accounted for a combined total of US$ 2119 million or 71% of the total contributions from Member States, or 44% of the total contributions from all sources.

Top 10 Member State contributors to the Programme budget 2014–2015, combining assessed and voluntary contributions (US$ million)



The top voluntary contributors for 2014–2015 are summarized below with a comparison against 2012–2013. This includes both Member States and other contributors. The top 10 voluntary contributors represent 60% of the total voluntary contributions under the Programme budget.

Top 10 voluntary contributors to the Programme budget 2014–2015 and Programme budget 2012–2013 (US$ million)

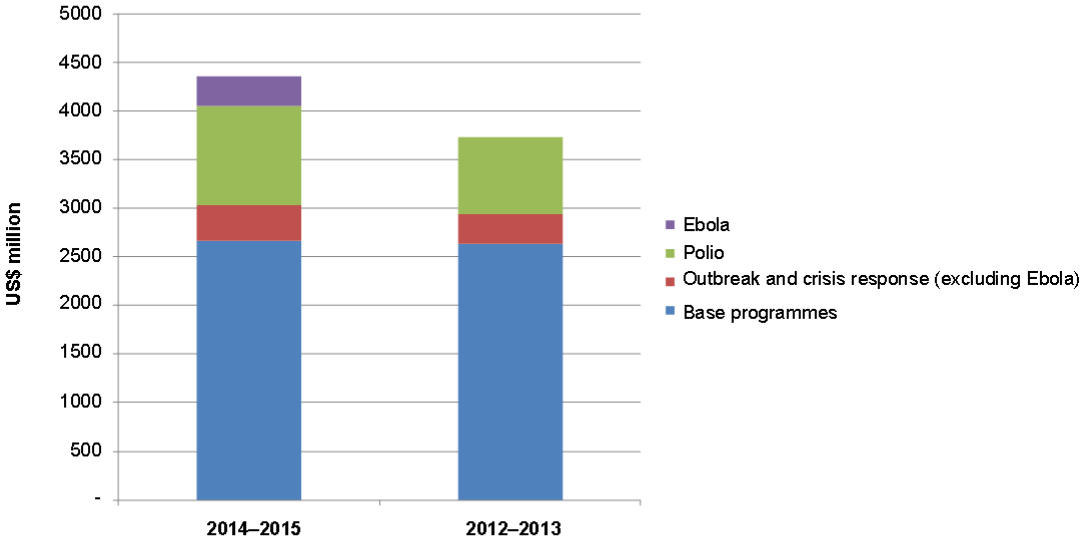


(c) Expenses

Total expenses for 2014–2015 for the implementation of the Programme budget were US$ 4357 million (US$ 3729 million in 2012–2013), representing an increase of US$ 627 million, or 14%, from 2012–2013. Expenses are recognized when goods and services are received and not when commitments or payments are made. The increase in expenses in 2014–2015 is mainly due to increased emergency-related expenses, including the Ebola emergency (US$ 312 million), and the expanded activities of the Global Polio Eradication Initiative.

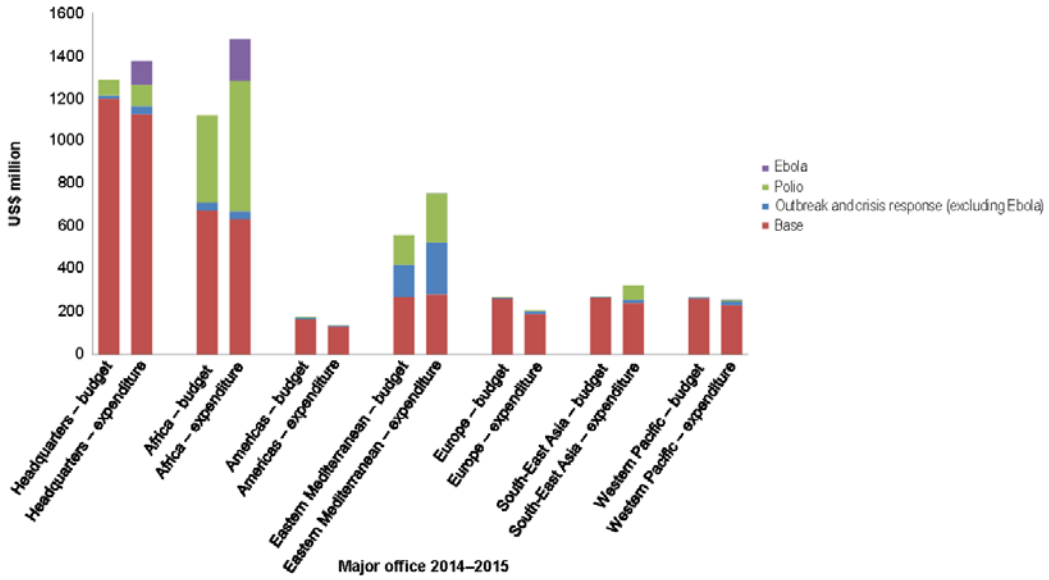
The proportions of the expenses that relate to base programmes, the Global Polio Eradication Initiative, Ebola and other activities of the Outbreak and crisis response segment are shown below. The percentage of total expenses that relates to the base programmes segment was 61% in 2014–2015, down from 71% in 2012–2013. The percentage relating to other segments has increased, with polio expenses representing 23%, Ebola 7% and other Outbreak and crisis response activities 9% of total expenses in 2014–2015.

Programme budget expenses by segment, 2014–2015 and 2012–2013 (US$ million)



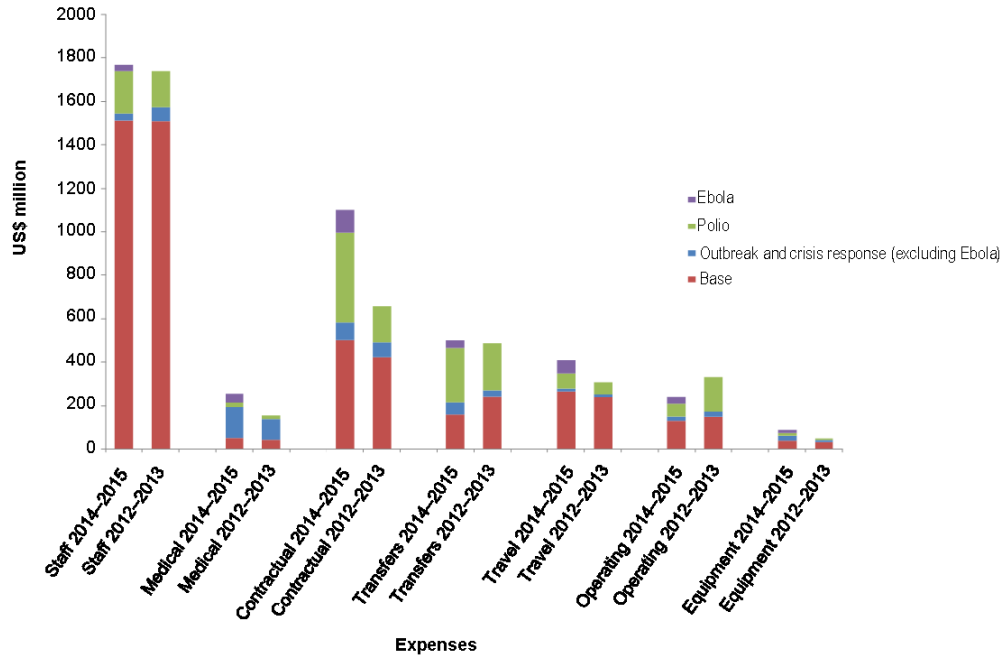
The chart below shows expenses for 2014–2015 compared with the Health Assembly-approved Programme budget, by major office. In the African Region, the main increases related to Ebola and polio, and in the Eastern Mediterranean Region, the largest increases were related to polio and the emergencies in the Syrian Arab Republic, Iraq, Yemen, Sudan and Afghanistan.

Programme budget expenses compared with the Health Assembly-approved budget by major office in 2014–2015 and 2012–2013 (US$ million)



The Figure below provides a summary of Programme budget expenses by expense type for 2014–2015 and 2012–2013.

Programme budget expenses by type in 2014–2015 and 2012–2013 (US$ million)



Staff costs were the largest type of expense and represented 41% of the total expenses incurred for the Programme budget 2014–2015. This represented the total cost of employing staff, including charges for base salary, post adjustment and any other types of entitlements paid by the Organization (e.g. pensions and insurances). Compared with 2012–2013, total staff and other personnel costs remained stable across the Organization. Across segments, base staff costs remained stable, while staff costs relating to polio increased from US$ 169 million in 2012–2013 to US$ 197 million in 2014–2015, mainly due to increases in the African and Eastern Mediterranean regions. Ebola accounted for staff costs of US$ 27 million in 2014–2015.

Contractual services represented 25% of overall expenses, were the second-largest type of expenses and represent the cost of contracts given to experts and service providers who supported the Organization in achieving its planned objectives. Contractual services expenses increased by US$ 441 million from 2012–2013 to 2014–2015. The main components are for agreements for performance of work, direct implementation activities and special services agreement contracts issued to individuals to perform activities on behalf of the Organization. Fellowships, training and security expenses are also included in contractual services. Within contractual services, polio, Ebola and other Outbreak and crisis response were the areas where the largest increases occurred between 2012–2013 and 2014–2015.

Transfers and grants represented 11% of overall expenses, and were highest in the African and Eastern Mediterranean regions. These expenses were for contracts signed with national counterparts (mainly health ministries as well as nongovernmental organizations) to perform activities in line with the Programme budget (direct financial cooperation). Close to 50% of all amounts recorded as transfers and grants are related to the Global Polio Eradication Initiative. The policies and procedures surrounding the use of direct financial cooperation arrangements were strengthened during 2014–2015 with the aim of strengthening accountability for the use of such funds.

General operating expenses reflect maintenance and operational running costs, including utilities and other office costs. These are incurred mainly at the local level and represented 6% of total expenses under the Programme budget in 2014–2015 (9% in 2012–2013).

Travel constituted 9% of the Organization's total expenses for the Programme budget in 2014–2015 with a total of US$ 408 million (US$ 308 million in 2012–2013). Travel expenses include airfare, per diem and other travel-related costs for staff and non-staff. The increased total travel costs were a result of increased non-staff travel related to emergencies – Ebola and other emergencies – and the Global Polio Eradication Initiative. The proportion of total travel costs for staff in fact decreased from 52% in 2012–2013 to 46% in 2014–2015.

The expenses for **medical supplies and materials** relate primarily to medical supplies purchased and distributed by the Organization for programme implementation as well as medical literature. These accounted for 6% of total expenses in 2014–2015 (4% in 2012–2013). The largest increases in absolute terms were in the African and Eastern Mediterranean regions and were caused by emergency medical supplies in support of Ebola, as well as the emergencies in Libya, the Syrian Arab Republic and for supplies in support of polio eradication activities.

(d) Financial risks

The Organization manages a number of financial risks, arising from its funding structure and from its decentralized operating environment. The Independent Expert Oversight Advisory Committee reviews such risks at a high level, and makes recommendations. Certain risks have attracted focused attention from Member States.

The biggest risk for WHO is the **uncertainty of long-term funding**. The financing dialogue meetings have examined the overall projected financing for the Organization, and alignment of financing with WHO's budget. While the financing dialogue has improved short-term financing of the budget, ensuring near full financing for all programmes in 2014–2015, and already near full financing for the 2016–2017 biennium, long-term risks remain. The Organization continues to be dependent on a relatively small donor base for its funding.

A large source of funding that will not continue beyond 2019 is that for the **Global Polio Eradication Initiative**. In 2014–2015, 23% of total Programme budget expenditure was spent on the Global Polio Eradication Initiative. Alternative sources of funding need to be found for those staff that the Organization plans to retain beyond the polio funding, as part of the polio legacy planning. In respect of those polio-funded staff that the Organization does not intend to retain, a reserve is in place, and will be further built up, in order to ensure sufficient funds for separation entitlements.

The most significant **long-term staff liability** is for after-service health care costs. The latest actuarial valuation estimates the overall WHO health insurance liability at US$ 1523 million, including the after-service future estimated cost. Current WHO funding is US$ 609 million, therefore leaving a net deficit of US$ 914 million. To ensure eventual financing of this deficit, the Organization has a built-in budgetary mechanism, through its staff costing model, to ensure fair burden-sharing by all WHO contributors.

The health care scheme provides medical reimbursements for serving and retired staff members, and their dependents, subject to strict rules and limits. The Staff Health Insurance scheme covers other entities, namely PAHO, UNAIDS, UNITAID, IARC and the International Computing Centre, and produces separate financial statements. In order to establish a long-term mechanism to ensure, eventually, full financing of the liability, changes to the Staff Health Insurance contribution rates were approved in 2011, affecting both the Organization and the scheme's participants, and covering all entities. The latest actuarial assessment projected that the plan will reach full funding in 2037. Other cost containment measures are also planned.

The Organization receives contributions and makes payments in currencies other than the United States dollar and it is exposed to **foreign exchange currency risk** arising from fluctuations in currency exchange rates. Forward foreign exchange contracts are transacted in order to hedge non-United States dollar currency exposures and to manage short-term cash flows. These currency risk management measures have been effective in protecting the Organization's current budget from short-term volatility in exchange rates. The Organization is also exposed to **investment** risks relating both to its short-term funds held for programme activities and long-term funds to meet its longer-term liabilities. The Advisory Investment Committee regularly reviews the investment policies and the investment performance and risk for all investment portfolios.

In addition to the needs expressed in its biennial budgets, the Organization has **long-term infrastructure needs**, notably for its buildings and for information technology (IT) systems. The Capital Master Plan describes all

major building needs, and is funded through the Real Estate Fund. The largest project within the Plan is a comprehensive headquarters refurbishment strategy, which was proposed for approval separately at the Sixty-ninth World Health Assembly,[1] together with a proposal for financing. In respect of IT, an IT fund has been established to manage the major IT infrastructure. Financing, and expenditure, for both the Real Estate and IT funds, is reported to the Health Assembly through the present report.

(e) Transparency, accountability and compliance

Following the approval of the Programme budget 2014–2015, a critical element of the WHO reform and a recommendation from the financing dialogue of 2013 was rolled out. This entails a more strategic allocation and systematic management of the pooled flexible resources in order to provide adequate financing to all programme areas and ensure operational capacity across entities at all three levels of the Organization. In practical terms the release of flexible resources takes place several times during the biennium following careful Organization-wide monitoring and review of available resources, funding gaps and projected income as well as projected implementation rates. Building on the 2014–2015 experience, the strategic distribution of flexible funds will incrementally be further refined in the biennium 2016–2017.

This mechanism has already allowed greater alignment of funds across programmes and major offices. This has resulted in the differential between the least and the best funded programmes/offices being reduced compared with 2012–2013. The flexible voluntary contributions donated by a limited number of donors remain essential to efforts to continue to improve alignment.

The launch of the WHO programme budget web portal has resulted in a major improvement in financial transparency. The portal gives details on sources of financing and the flow of resources throughout the Organization, down to individual country level. Inputs from Member States and other partners during the financing dialogue have shaped how the portal works and the information that is displayed. Over time the web portal will become the main repository for programmatic information, a role that is being piloted during this overall performance assessment.

Other transparency initiatives include the development of a series of dashboards showing details of management compliance against a series of Key Performance Indicators. This will be an important tool both for comparison between budget centres or other management entities as well as for tracking improvements of single entities over time.

The development of an accountability compact between the Director-General and Assistant Directors-General similarly exemplifies how WHO is striving for greater openness and clarity on what is expected of senior WHO officials. The annual letter of representation along with the internal control self-assessment checklist, which are internal control statements on the use of resources by each Regional Director and Assistant Director-General, has also been successfully implemented.

Action at all three levels of the Organization are key to improvements in accountability across WHO. One area that has received particular attention is the manner in which WHO manages direct financial cooperationat country level. Greater vigilance and policy changes have led to a significant improvement – one indicator of this being the reduction in outstanding direct financial cooperation reports by 65% from the end of 2013 to the end of 2015.

A number of complementary processes have improved accountability at country level. They include audits by internal and external auditors; combined administrative, financial and programmatic reviews; and an independent external evaluation of WHO's country presence. All regional offices have now established dedicated compliance units and the Regional Directors are regularly taking action on the findings in order to enforce accountability at regional and country level.

Since 2014, when the corporate risk register was launched, risk management has become an integral part of WHO's operational processes. With the adoption of the comprehensive risk management policy in November 2015, risk management has now been embedded into operational planning. Each WHO budget centre is now required to identify risks; report these risks to senior management according to their level of criticality; and

[1] See documents A69/56 and EB138/2016/REC/1, resolution EB138.R7.

provide recommendations for action to implement mitigation measures. A systematic central monitoring mechanism has been established to facilitate this exercise and ensure regular follow-up. Risk management provides information that supports decision-making in WHO. Strategic and operational planning uses the risk data captured in the exercise to develop and monitor progress on WHO's Programme budget.

The continued relocation of corporate-wide finance, human resources and IT services to Malaysia, at lower staff costs than Geneva, continues to provide efficiencies. Noteworthy during 2014–2015 has been the implementation of harmonized, globally shared IT products. This has led to better ways of delivering the services, improved user productivity across WHO locations, reduction of duplication, and financial efficiencies. All regional offices have also introduced efficiencies; examples include reduction in travel and increased use of video. Some regions have made dedicated efforts to reduce printed material for regional governance and other major meetings. In part as a result of these initiatives, the total expenditure for Category 6 for the biennium 2014–2015, encompassing the Organization's management, infrastructure and administrative functions, was 7.5% lower than budgeted.

SECTION 1. ACHIEVEMENTS BY CATEGORY AND PROGRAMME AREA

Category 1

COMMUNICABLE DISEASES

The overall aim of this category is to reduce the burden of communicable diseases, including HIV/AIDS, tuberculosis, malaria, neglected tropical diseases and vaccine-preventable diseases.

The biennium has seen encouraging results and important achievements surpassing the original targets of the Millennium Development Goals era for HIV/AIDS, tuberculosis and malaria. These include major increases in coverage of key interventions, for example people living with HIV receiving antiretroviral treatment, patients suffering from multidrug-resistant tuberculosis being rapidly diagnosed and placed on the appropriate treatment, and the increase in the number of children under five years of age in sub-Saharan Africa sleeping under insecticide-treated mosquito nets. WHO's work in this category has contributed to these achievements.

Viral hepatitis did not feature in the Millennium Development Goals, reflecting a general lack of political engagement and funding. However, during the biennium 2014–2015 WHO took the lead in elevating the global hepatitis agenda, which culminated in the first Global Hepatitis Summit in 2015. WHO published guidelines that can help countries develop comprehensive national hepatitis programmes. WHO developed a first global health sector strategy on viral hepatitis 2016–2021 that puts forward a vision for eliminating hepatitis by 2030. A draft of the strategy is being submitted for consideration by the Sixty-ninth World Health Assembly.[1] However, scaling up treatment to match this vision will depend on major reductions in the prices of hepatitis medicines.

[1] See document A69/32.

To make headway in prevention and control of neglected tropical diseases, an integrated approach focusing on poor, rural and marginalized populations has been employed with success during the biennium.

Ambitious new targets for HIV, tuberculosis and malaria have been set by WHO and UNAIDS. Following on from this, the Sustainable Development Goals go far beyond the Millennium Development Goals agenda in broadening the scope of attention to specifically include neglected tropical diseases and viral hepatitis.

WHO hosted the secretariat that collected data on the progress made against the goals and strategic objectives of the Global Vaccine Action Plan, facilitated the independent review, through the Strategic Advisory Group of Experts in 2014 and 2015, and reports to the Health Assembly. Despite progress being seen in several areas overall the world is not on track for achieving the mid-term targets.

CATEGORY 1 OVERALL FINANCIAL SUMMARY, 2014–2015 (US$ 000)

	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Health Assembly-approved budget	266 700	19 500	107 400	30 600	89 900	71 500	255 200	840 800
Funds available (as at 31 December 2015)								
Flexible funds	60 967	14 902	21 326	4053	11 365	11 990	31 852	156 455
Voluntary contributions specified	199 914	18 270	64 289	30 447	37 890	51 265	242 883	644 985
Total	**260 881**	**33 172**	**85 615**	**34 500**	**49 255**	**63 255**	**274 735**	**801 440**
Funds available as a % of budget	98%	170%	80%	113%	55%	88%	108%	95%
Staff costs	82 042	18 939	26 906	13 471	16 771	28 323	137 902	324 354
Activity costs	144 005	11 677	52 912	17 758	29 885	31 145	105 433	392 815
Total expenditure	**226 047**	**30 616**	**79 818**	**31 229**	**46 656**	**59 468**	**243 335**	**717 169**
Expenditure as a % of approved budget	85%	157%	74%	102%	52%	83%	95%	85%
Expenditure as a % of funds available	87%	92%	93%	91%	95%	94%	89%	89%
Staff expenditure by major office	25%	6%	8%	4%	5%	9%	43%	100%

1.1 HIV/AIDS

OUTCOME 1.1 INCREASED ACCESS TO KEY INTERVENTIONS FOR PEOPLE LIVING WITH HIV

From evidence to action: WHO's experience from HIV/AIDS informs the fight against hepatitis

In 2015, thanks to an unprecedented multisectoral effort, the spread of HIV began to reverse, showing that the global target for Millennium Development Goal 6 on HIV/AIDS can be achieved.

The WHO Global Health Sector Strategy on HIV/AIDS 2011–2015 was pivotal to the global effort and provided the strategic direction for the health sector response. The outcome has been that 16 million[1] people living with HIV now have access to antiretroviral therapy; a massive scale-up of comprehensive HIV prevention programmes – including 10 million medical male circumcisions in eastern and southern Africa; and significant progress towards the elimination of mother-to-child transmission of HIV and syphilis.

One of WHO's roles is to act as a driving force, providing technical leadership to a global coalition of countries, development partners and civil society:

- At the start of the biennium in 2014, annual new HIV infections dropped to 2.0 million, down from 3.1 million in 2000; a decline of 35%.
- From a peak in 2004, HIV-related deaths fell by 42% by 2014. This also means that the number of people living with HIV rose from an estimated 9.0 million in 1990 to 36.9 million in 2014, as survival rates improved as a result of treatment.
- Annual new infections among young people between 15 and 19 years of age fell by 37% between 2000 and 2014 primarily as a result of behavioural change, including increased condom use, fewer multiple sexual partnerships and delayed sexual debut.
- The use of antiretrovirals in the prevention of mother-to-child transmission of HIV has been successful and elimination is now a realistic goal, and WHO is leading the process of validating elimination in countries. More than 80 countries now report fewer than 50 new HIV infections among children each year. In June 2015, Cuba became the first country to be certified as having eliminated new HIV infections in children altogether.

A further element of WHO's leadership role is to translate emerging clinical and operational research, evidence and experience from the field and international best practice into clear policy, operational and clinical recommendations.

Over the course of the biennium guidelines have been produced on the "treat-all" approach. The guidelines provided a sound technical rationale for universal access to antiretroviral therapy for all people living with HIV; strategic information to better guide responses along the cascade of HIV services; diversification of HIV testing approaches and services to expand knowledge of HIV status; comprehensive services for key populations to reduce exclusion; and strategic information to better monitor and guide HIV programmes.

Other normative, policy and operational guidance has focused on HIV self-testing; voluntary medical male circumcision; pre-exposure prophylaxis of HIV infection; drug procurement; and HIV service delivery, especially for key populations.

WHO support to countries helped translate evidence into action. Intensified support concentrated on a set of 58 focus countries. The result has been a significant reduction of the time lag between publication, adoption and implementation of new recommendations.

[1] The initial outcome target was to reach 15 million people on treatment with antiretroviral medication.

Through its presence on the ground, local knowledge and understanding of country contexts, WHO helped 74 countries access the resources they need from other partners – either through technical assistance for assessing national HIV programmes or by developing Global Fund HIV concept notes.

Central to WHO country support has been a focus on better data for decision-making. Used optimally, good data help countries understand and respond strategically to constantly shifting epidemics. This is particularly critical when resources are scarce and value for money is paramount. Disaggregated geographical and key population data are now used to support decisions at the global, national and local levels and WHO has increased its investment in population-based surveys and disease surveillance. The result: programmes deliver high-impact interventions to those populations and locations in greatest need, while at the same time national and global reporting is improved.

In 2014–2015, the WHO HIV and viral hepatitis programmes joined forces to revitalize global efforts to address the largely overlooked area of viral hepatitis. With highly effective hepatitis prevention and treatment interventions available (including hepatitis B virus vaccination, injection and blood safety standards and services, harm reduction for people who inject drugs, treatment for chronic hepatitis B infection and new curative treatment for chronic hepatitis C infection), the elimination of hepatitis B and hepatitis C as public health threats is feasible.

WHO has accelerated evidence review and guideline development processes to exploit these opportunities and to meet the needs of countries. New guidelines have been produced, including on the screening, care and treatment of persons with hepatitis C infection; the prevention, care and treatment of people with hepatitis B infection; and recognition, investigation and control of waterborne outbreaks of hepatitis E. These were complemented by guidance on hepatitis programme development, and the development of a set of standardized hepatitis indicators for monitoring and evaluation of hepatitis policies and services.

The above is an illustration of the work that has been done for this programme area (HIV/AIDS; and shows the contribution of WHO to the increased use of antiretrovirals and the reduction of mother-to-child transmission during pregnancy and delivery.

The table below shows overall output achievements by major office. For more detailed information on the work implemented under this programme area, including explanations of output ratings, please consult the programme budget web portal.[1]

(✓)Fully delivered/contributed (!) Partly delivered/contributed (X) Not delivered/contributed (n/a) Not applicable								
Output		Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
1.1.1.	Implementation and monitoring of the global health sector strategy on HIV/AIDS 2011–2015 through policy dialogue and technical support at global, regional and national level	✓	!	✓	✓	✓	✓	✓
1.1.2.	Adaptation and implementation of most up-to-date norms and standards in preventing and treating paediatric and adult HIV infection, integrating HIV and other health programmes, and reducing inequities	!	✓	✓	✓	✓	✓	✓

[1] Available at http://extranet.who.int/programmebudget/Biennium2016/Programme/Overview/155, accessed 7 April 2016.

Budget and expenditure by major office, 2014–2015 (US$ 000)

	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Health Assembly-approved budget	45 900	4000	14 200	5800	9600	10 100	41 900	131 500
Funds available (as at 31 December 2015)								
Flexible funds	16 645	5250	4751	956	2282	3843	5520	39 247
Voluntary contributions specified	29 394	2602	10 802	5651	5600	8081	40 842	102 972
Total	**46 039**	**7852**	**15 553**	**6607**	**7882**	**11 924**	**46 362**	**142 219**
Funds available as a % of budget	100%	196%	110%	114%	82%	118%	111%	108%
Staff costs	22 388	4775	5713	3133	3760	7139	23 914	70 822
Activity costs	19 825	1338	7935	2893	3865	4464	18 798	59 118
Total expenditure	**42 213**	**6113**	**13 648**	**6026**	**7625**	**11 603**	**42 712**	**129 940**
Expenditure as a % of approved budget	92%	153%	96%	104%	79%	115%	102%	99%
Expenditure as a % of funds available	92%	78%	88%	91%	97%	97%	92%	91%
Staff expenditure by major office	32%	7%	8%	4%	5%	10%	34%	100%

1.2 TUBERCULOSIS

OUTCOME 1.2 INCREASED NUMBER OF SUCCESSFULLY TREATED TUBERCULOSIS PATIENTS

Progress in expanding access to rapid diagnostics – a critical step in overcoming the crisis of multidrug-resistant tuberculosis

Joe, a South African man, has been living with HIV for over five years. At a recent check-up at his local HIV care centre, a physician noticed Joe had a persistent cough and was losing weight. She suspected the reason might be tuberculosis (TB), and was able to order a test for TB that gave accurate results back in just two hours. The results included information that Joe's strain of TB was resistant to rifampicin – the most powerful first-line drug and a marker for multidrug-resistant TB (MDR-TB). Joe was able to be quickly put on a treatment regimen that the physician was confident would cure him of MDR-TB.

Just a few years ago this story wouldn't have had such a positive ending. Using traditional methods for detecting TB, Joe's sputum would have first been stained and examined under a microscope. If TB bacilli were seen (often there are not enough for a microscopist to see, especially when the specimen comes from a person with HIV or from a child) – Joe would have been put on a standardized six-month regimen that may not have been effective for his TB strain. After failing treatment, he would have been put on another standardized regimen. If the physician had access to testing for drug resistance, a specimen would have been sent to a centralized laboratory with high biosafety conditions and specially trained staff, and Joe's specimen would have been cultured. Weeks or even months later, the results would have been ready to allow Joe to finally be put on the regimen that would cure him.

The game changer for Joe has been Xpert MTB/RIF, a rapid test for the detection of TB and rifampicin resistance (a marker for MDR-TB). The test was first recommended by WHO in December 2010 following a comprehensive review of the evidence. Xpert MTB/RIF was then quickly adopted by countries as an effective tool for the rapid detection of TB and drug-resistant TB at lower levels of the health system. As of 2015, 119 low- and middle-income countries had the capacity for Xpert MTB/RIF testing with 4672 testing machines and 6.2 million test cartridges procured in the public sector around the world. WHO facilitated this roll-out by providing technical assistance to countries, developing practical guidance, convening partners and donors to share best practices, and ensuring coordination of efforts. Substantial funding and technical support from sources including the Global Fund, the United States Agency for International Development (USAID), the International Drug Purchase Facility (UNITAID), the President's Emergency Plan for AIDS Relief, FIND, TB REACH and Médecins Sans Frontières also enabled countries to make this possible.

This strengthened country capacity for rapid TB testing has helped make strides against the MDR-TB epidemic. In 2012, WHO called for MDR-TB to be addressed as a public health crisis. Globally in 2014, 480 000 people fell ill with MDR-TB and there were 190 000 MDR-TB deaths according to WHO estimates. A total of 123 000 patients with MDR-TB were detected and notified in the same year. This represents an increase of 130% compared with 2010, when Xpert MTB/RIF was introduced. Scaling up of diagnostic capacity in countries to detect people with drug-resistant TB is a key first step in the fight against MDR-TB. Matching this with improved access to quality treatment and care completes the chain to enable people with MDR-TB to obtain the care they need. Although still insufficient, more TB patients were reported to have been tested for drug resistance in 2014 than in any previous year. Worldwide, 58% of previously treated patients and 12% of new cases were tested, up from 17% and 8.5%, respectively, in 2013. This improvement is mainly due to the adoption of rapid molecular tests.

Over 2013–2016, the TBXpert project launched by the WHO Global TB Programme with funding of US$ 25.9 million from UNITAID, has played a key role in expanding access to rapid tests. The project provided 237 testing machines and 1.4 million test cartridges to 21 high-burden countries. This significantly built capacity for TB detection and rifampicin resistance testing to allow for the detection of TB in 230 000 people and of drug-resistant TB in 61 000 people.

Furthermore, in 2014 WHO issued updated policy guidance with broadened recommendations on the use of Xpert MTB/RIF. In addition to being strongly recommended for detecting TB among people at risk of drug-resistant TB and HIV-associated TB, Xpert MTB/RIF is now recommended to be used for detecting TB in children, for detecting extra pulmonary TB, and when resources allow, for detecting TB among all people in whom TB is suspected.

As of 2014, most high-burden countries reported the inclusion of WHO recommendations into national policies for detecting TB in people at risk of drug-resistant TB (69%) and in people with HIV-associated TB (60%). Many countries have also already adopted WHO recommendations on its use for detecting TB in children (50%) and for extrapulmonary TB (41%).

To further expand access to rapid tests for TB and drug-resistant TB, WHO is working on:

- evaluating evidence on the performance of new diagnostics for the development of policy guidance on their use
- guiding countries in developing effective diagnostic algorithms to broaden patient access
- providing and coordinating technical assistance to countries to enable optimal use of available technologies

From 2016, the global goal has shifted from controlling TB to ending the global TB epidemic. Ending the TB epidemic by 2030 is the goal of the WHO End TB Strategy and among the targets of the Sustainable Development Goals. The End TB Strategy emphasizes the importance of early diagnosis and prompt treatment of all people of all ages with any form of drug-susceptible or drug-resistant TB. WHO is working closely with countries and partners to ensure that rapid TB diagnostics and drug-susceptibility testing are made available to all who need it. Along with this push to scale up diagnostic capacity, WHO is also supporting countries in building capacity to deliver effective treatment and care. With this impetus, ending the MDR-TB crisis as well as the TB epidemic is within our reach.

The above is an illustration of the work in relation to programme area on tuberculosis. WHO work in expanding access to rapid diagnosis of tuberculosis has contributed to the outcome indicator related to the number of tuberculosis patients with confirmed MDR-TB being placed on treatment.

The table below shows overall output achievements by major office. For more detailed information on the work implemented under this programme area, including explanations of output ratings, please consult the programme budget web portal.[1]

(✓)Fully delivered/contributed (!) Partly delivered/contributed (X) Not delivered/contributed (n/a) Not applicable								
Output		**Africa**	**Americas**	**South-East Asia**	**Europe**	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**
1.2.1.	Intensified implementation of Stop TB Strategy to scale up care and control, with focus on reaching vulnerable populations, strengthening surveillance, and alignment with health sector plans facilitated	✓	✓	✓	✓	✓	✓	✓
1.2.2.	Updated policy guidance and technical guidelines on HIV-related tuberculosis, delivery of care for patients with multidrug-resistant tuberculosis, tuberculosis diagnostic approaches, tuberculosis screening in risk groups and integrated community-based management of tuberculosis	✓	!	✓	✓	!	✓	✓

Budget and expenditure by major office, 2014–2015 (US$ 000)

	Africa	**Americas**	**South-East Asia**	**Europe**	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**	**Total**
Health Assembly-approved budget	16 900	1100	30 400	11 000	20 900	14 400	36 200	130 900
Funds available (as at 31 December 2015)								
Flexible funds	7639	1094	2821	1653	1814	2453	3772	21 246
Voluntary contributions specified	17 539	1061	19 674	11 595	3541	8670	34 400	96 480
Total	**25 178**	**2155**	**22 495**	**13 248**	**5355**	**11 123**	**38 172**	**117 726**
Funds available as a % of budget	149%	196%	74%	120%	26%	77%	105%	90%
Staff costs	11 181	1212	5893	5129	3276	6237	25 556	58 484
Activity costs	10 694	762	15 501	6024	1774	4252	11 633	50 640
Total expenditure	**21 875**	**1974**	**21 394**	**11 153**	**5050**	**10 489**	**37 189**	**109 124**
Expenditure as a % of approved budget								
	129%	179%	70%	101%	24%	73%	103%	83%
Expenditure as a % of funds available								
	87%	92%	95%	84%	94%	94%	97%	93%
Staff expenditure by major office								

[1] Available at http://extranet.who.int/programmebudget/Biennium2016/Programme/Overview/156, accessed 7 April 2016.

1.3 MALARIA

OUTCOME 1.3. INCREASED ACCESS TO FIRST-LINE ANTIMALARIAL TREATMENT FOR CONFIRMED MALARIA CASES

The global technical strategy – the framework for malaria control and elimination

Since the beginning of this millennium, there has been a dramatic decline in the global burden of malaria. Between 2000 and 2015, malaria death rates plunged by 60%, translating into 6.2 million lives saved. The rate of new cases of malaria (incidence) fell by 37%. The malaria-focused target of the Millennium Development Goals, adopted in 2000, which called for halting and beginning to reverse the incidence of malaria by 2015, has been achieved.

Global progress resulted, in large part, from the massive deployment of effective malaria control interventions. Nearly 1 billion insecticide-treated mosquito nets have been distributed in sub-Saharan Africa over the last 15 years. Rapid diagnostic tests have made it easier to swiftly distinguish between malarial and non-malarial fevers, enabling timely and appropriate treatment. Artemisinin-based combination therapies, introduced widely over the past decade, have been highly effective against *P. falciparum*, the most prevalent and lethal malaria parasite affecting humans.

However, significant challenges remain. About 3.2 billion people — nearly half of the world's population — remain at risk of malaria. In 2015, there were an estimated 214 million new cases of malaria, and approximately 438 000 deaths. Sub-Saharan Africa continues to shoulder the heaviest malaria burden: In 2015, this one region accounted for approximately 90% of all malaria cases and deaths.

In many countries, progress is threatened by the rapid development and spread of mosquito resistance to insecticides. Drug resistance could also jeopardize recent gains in malaria control. To date, parasite resistance to artemisinin — the core compound of the best available antimalarial medicines — has been detected in five countries of the Greater Mekong subregion.

To address remaining gaps in malaria control and elimination, the Health Assembly in May 2015 adopted the global technical strategy for malaria 2016–2030.[1] The timeline of 2016–2030 is aligned with the 2030 Agenda for Sustainable Development, endorsed last year by all United Nations Member States.

The global technical strategy, developed and led by WHO, is the first malaria strategy endorsed by the Health Assembly since 1993. It was the result of an extensive process involving the participation of more than 400 malaria experts from 70 countries and consultations in seven regions. Its goals, based on data analysis, are ambitious but attainable:

- Reducing the rate of new malaria cases by at least 90%
- Reducing malaria death rates by at least 90%
- Eliminating malaria in at least 35 countries
- Preventing a resurgence of malaria in all countries that are malaria-free

WHO is committed to supporting Member States to achieve the targets of the GTS. Since the launch of the GTS in May 2015, the Organization has been aligning regional strategies with this global framework and has provided technical support to countries as they adapt their national malaria strategies to the GTS.

The scale-up of malaria control efforts in recent years, coupled with major investments in malaria research, has led to the development of new tools and strategies aimed at further consolidating malaria control goals. As a result, there has been a growing need for WHO to rapidly review new evidence and update its technical recommendations.

[1] See resolution WHA68.2.

Since 2010, the WHO Global Malaria Programme initiated an extensive review of WHO's policy-making process for malaria control and elimination. The aim was to establish a more rigorous, efficient, and transparent process that would allow for timely responses to the ongoing challenges faced by national malaria programmes. Following the recommendation of an external advisory group, a Malaria Policy Advisory Committee was established in 2011 to provide independent advice to WHO on all policy areas relating to malaria control and elimination. The Advisory Committee meets twice annually and is comprised of 15 leading malaria experts. This strengthened policy-setting architecture has repositioned WHO as the most credible international public health authority on malaria policy, guidance and technical support in malaria-endemic countries. In the biennium 2014–2015, Malaria Policy Advisory Committee guided the development of the GTS and provided strategic advice to the Global Malaria Programme on a range of technical issues,[1] from recommendations on the use of mass drug administration to the risks associated with vector control scale-back.

Other key malaria guidance published by WHO in the last biennium includes an update to the guidelines for the treatment of malaria (developed in collaboration with the WHO Guidelines Review Committee); a technical brief on the control and elimination of *P. vivax* malaria; and recommendations on malaria diagnostics in low-transmission settings.

With technical staff in all malaria-endemic countries, WHO has a unique footprint and is well poised to take the malaria agenda forward. In the last biennium, the Organization provided ongoing support to endemic countries as they developed gap analyses and grant proposals for the Global Fund to Fight AIDS, Tuberculosis and Malaria. WHO's technical experts also supported countries in all regions as they implemented national strategic plans and conducted programme reviews.

To combat the spread of antimalarial drug resistance, in 2013 WHO launched an emergency response to artemisinin resistance (ERAR) in the Greater Mekong subregion. The Organization has since provided technical support to affected countries across the GMS through its country offices and through a dedicated ERAR regional hub in Cambodia. A WHO *Strategy for malaria elimination in the Greater Mekong Subregion 2015–2030*, launched in 2015, is based on and aligned with the GTS.

As part of its mandate, the Global Malaria Programme keeps an independent score of global progress in the fight against malaria. Its flagship annual publication, the *World malaria report*, contains the most up-to-date data on malaria control and elimination globally. The latest report, released in December 2015, notes that global funding for malaria control increased from US$ 960 million in 2005 to US$ 2.5 billion in 2014. To achieve the goals of the GTS, funding will need to increase substantially from current levels, reaching US$ 8.7 billion annually by 2030.

In addition to robust financing, future progress on malaria can be accelerated through the development of new tools and innovations in service delivery, strong political commitment and increased multisectoral collaboration.

This example from programme area on malaria demonstrates the strength of having a single, evidence-based, strategy, endorsed by Member States, around which a multitude of stakeholders can actively contribute to reach the desired outcome of increased access to first-line malarial treatment for confirmed cases.

The table below shows overall output achievements by major office. For more detailed information on the work implemented under this programme area, including explanations of output ratings, please consult the programme budget web portal.[2]

[1] Information and guidance notes issued in line with MPAC recommendations can be found on the Global Malaria Programme website at: http://www.who.int/malaria/mpac/policyrecommendations/en/.

[2] Available at http://extranet.who.int/programmebudget/Biennium2016/Programme/Overview/157, accessed 7 April 2016.

(✓)Fully delivered/contributed (!) Partly delivered/contributed (X) Not delivered/contributed (n/a) Not applicable								
Output		Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
1.3.1.	Countries enabled to implement malaria strategic plans, with focus on improved diagnostic testing and treatment, therapeutic efficacy monitoring and surveillance through capacity strengthening	!	✓	✓	✓	✓	✓	✓
1.3.2.	Updated policy recommendations, strategic and technical guidelines on vector control, diagnostic testing, antimalarial treatment, integrated management of febrile illness, surveillance, epidemic detection and response	!	✓	✓	✓	✓	✓	✓

Budget and expenditure by major office, 2014–2015 (US$ 000)

	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Health Assembly-approved budget	21 300	500	13 400	1100	13 800	12 600	28 900	91 600
Funds available (as at 31 December 2015)								
Flexible funds	8484	2638	2685	454	2464	1876	4850	23 451
Voluntary contributions specified	20 304	1393	9032	601	4479	10 503	28 893	75 205
Total	**28 788**	**4031**	**11 717**	**1055**	**6943**	**12 379**	**33 743**	**98 656**
Funds available as a % of budget	135%	806%	87%	96%	50%	98%	117%	108%
Staff costs	12 555	2327	4514	405	3031	6274	16 700	45 806
Activity costs	10 880	1505	6883	644	3554	5276	9731	38 473
Total expenditure	**23 435**	**3832**	**11 397**	**1049**	**6585**	**11 550**	**26 431**	**84 279**
Expenditure as a % of approved budget	110%	766%	85%	95%	48%	92%	91%	92%
Expenditure as a % of funds available	81%	95%	97%	99%	95%	93%	78%	85%
Staff expenditure by major office	27%	5%	10%	1%	7%	14%	36%	100%

1.4 NEGLECTED TROPICAL DISEASES

OUTCOME 1.4. INCREASED AND SUSTAINED ACCESS TO ESSENTIAL MEDICINES FOR NEGLECTED TROPICAL DISEASES

National ownership and partners l are successful in fighting neglected tropical diseases

Neglected tropical diseases are endemic in 149 countries. They affect more than 1 billion people who live in conditions of poverty, in close proximity to vectors and livestock, and with limited access to safe water and basic health care. In most cases one individual is affected simultaneously by more than one of these diseases, with an impact on productivity, pregnancy, childhood growth and development, and affecting individuals in the prime of life.

Strong country leadership, increased commitment by partners and availability of donated medicines defined the progress made during 2014–2015. Many countries managed to successfully implement control programmes, with some achieving elimination targets ahead of time. Measures including domestic contributions to expand existing programmes and cross-sectoral involvement have been introduced and have increasingly engaged communities, nongovernmental organizations and the private sector.

A broader multisectoral approach supported by partners has enhanced the coordination and management of programmes at national level, leading to more than 1 billion treatments being provided to cover 853 million people for at least one disease in 2014 compared with 791 million in 2013. In the same context, WHO coordinated the shipment of 1.3 billion and 1.5 billion donated tablets to Member States in 2014 and 2015, respectively. A scale-up of this magnitude requires strengthening the capacity of countries to cope with increased implementation. Over the past two years and by identifying priorities, several training programmes for national programme managers have been held, allowing “cascade” training of health care providers at district and peripheral levels.

Unprecedented progress has also been achieved in efforts to eradicate dracunculiasis. With only four countries (Chad, Ethiopia, Mali and South Sudan) reporting cases, only 22 human cases were reported in 2015 – the lowest ever – compared with 126 in 2014 and 148 in 2013. The progress is largely due to a steep decline in the number of cases in South Sudan, bringing the world closer to WHO’s roadmap target of interrupting global transmission. Currently, surveillance is at its highest level in the four countries and also in all countries at risk of reintroduction of the disease.

Substantial headway has also been made in regard to diseases requiring individual case management and here two examples stand out: human African trypanosomiasis and visceral leishmaniasis. For human African trypanosomiasis, only 3796 new cases were reported in 2014 – the lowest level recorded since the start of systematic global data collection 75 years ago. This compares favourably with the 6314 cases reported in 2013 and represents a drop of almost 40% in just one year. Continued progress means that elimination of visceral leishmaniasis as a public health problem can be achieved in South-East Asia by 2020. In 2014, Bangladesh achieved the elimination target in around 98% of its subdistricts (call *upazillas*) and India in around 82% of the endemic blocks (ie. subdistricts). Nepal maintained the elimination target in all its 12 districts.

Strengthening capacity for vector ecology and management has emerged as a top priority for WHO as the vectors have become highly sensitive to climate variables. As diseases spread by insects are expanding due to rapid, unplanned urbanization, population movements and environmental changes, WHO supported a study on estimation of burden of a dengue burden estimation in five countries and a study of its economic burden in three countries during 2014–2015. Dengue is now present in more than 150 countries and the spread of chikungunya and more recently Zika virus disease by the same vector that transmits dengue has added to the global challenge. As current programmes rely mostly on control of mosquito populations, the need for integrated vector control has become urgent and innovative tools and approaches are needed. In this context WHO is supporting an initiative which aims at bolstering the development of innovative vector control tools for large-scale use.

Over the past two years, WHO has also used the lessons learnt in tackling rabies as a model to promote programmes for the control of other neglected zoonoses. One of the key strategies is to provide greater access

to affordable and quality-assured veterinary health commodities and wide-ranging intersectoral collaboration involving all segments of the human and animal health sectors.

WHO has also strengthened its focus on better integrating water, sanitation and hygiene (WASH) services with other public health interventions. In 2015, it launched a global strategy with a five-year agenda, demonstrating global commitments to bringing together the WASH and public health constituencies, particularly on behalf of the poorest communities most in need.

Resolution WHA66.12, adopted by the Health Assembly in 2013, called for scale-up of interventions to reach roadmap targets by 2020 through continued country ownership of programmes and effective programmatic and financial planning. WHO's third report on neglected tropical diseases (2015)[1] focuses on the need to generate innovative domestic investment to sustainably address social and health inequities. The case for smarter domestic investment is strong and achievable as it represents as little as 0.1% of current domestic expenditure on health in affected low- and middle-income countries for the period 2015–2030.

Control of neglected tropical diseases must become an integral part of national health plans and budgets if it is to achieve the scale of universal coverage as prescribed in Target 3.3 of the Sustainable Development Goals. Action towards this target is already being taken in several countries. Elimination and control of neglected tropical diseases is a "litmus test" for universal health coverage, and success in collectively tackling these diseases can be used as a tracer of equity in progress towards achieving universal health coverage (Target 3.8), universal access to safe water (Target 6.1) and sanitation (Target 6.2).

As described above, it is evident that a multisectoral approach bears fruit. The contribution of WHO in the coordination of donated neglected tropical disease medicines links directly to the outcome of increased and sustained access to essential medicines for these diseases.

The table below shows overall output achievements by major office. For more detailed information on the work implemented under this programme area, including explanations of output ratings, please consult the programme budget web portal.[2]

(✓)Fully delivered/contributed (!) Partly delivered/contributed (X) Not delivered/contributed (n/a) Not applicable								
Output		**Africa**	**Americas**	**South-East Asia**	**Europe**	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**
1.4.1.	Implementation and monitoring of the WHO road map for neglected tropical diseases facilitated	✓	!	✓	n/a	!	✓	✓
1.4.2.	Implementation and monitoring of neglected tropical disease control interventions facilitated by evidence-based technical guidelines and technical support	✓	✓	✓	✓	!	✓	✓
1.4.3.	New knowledge, solutions and implementation strategies that respond to the health needs of disease-endemic countries developed through strengthened research and training	n/a	n/a	n/a	n/a	n/a	n/a	✓

[1] Investing to overcome the global impact of neglected tropical diseases: third WHO report on neglected diseases 2015. Geneva: World Health Organization; 2015 (http://apps.who.int/iris/bitstream/10665/152781/1/9789241564861_eng.pdf?ua=1, accessed 29 March 2016).

[2] http://extranet.who.int/programmebudget/Biennium2016/Programme/Overview/158, accessed 7 April 2016.

Budget and expenditure by major office, 2014–2015 (US$ 000)

	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Health Assembly-approved budget	19 400	4600	8600	400	6300	8300	92 400	140 000
Funds available (as at 31 December 2015)								
Flexible funds	10 968	2687	7248	148	1634	1858	10 980	35 523
Voluntary contributions specified	26 615	2403	5434	228	1860	3846	79 934	120 320
Total	**37 583**	**5090**	**12 682**	**376**	**3494**	**5704**	**90 914**	**155 843**
Funds available as a % of budget	194%	111%	147%	94%	55%	69%	98%	111%
Staff costs	9 475	2628	5345	116	717	1592	41 370	61 243
Activity costs	20 838	2274	6705	268	2339	3858	40 141	76 423
Total expenditure	**30 313**	**4902**	**12 050**	**384**	**3056**	**5450**	**81 511**	**137 666**
Expenditure as a % of approved budget	156%	107%	140%	96%	49%	66%	88%	98%
Expenditure as a % of funds available	81%	96%	95%	102%	87%	96%	90%	88%
Staff expenditure by major office	15%	4%	9%	0%	1%	3%	68%	100%

1.5 VACCINE-PREVENTABLE DISEASES

OUTCOME 1.5. INCREASED VACCINATION COVERAGE FOR HARD-TO-REACH POPULATIONS AND COMMUNITIES

Development and testing of Ebola vaccine

In July 2015 – a mere year and a half after a devastating Ebola epidemic broke out in West Africa – preliminary results on the possibility of controlling the spread of the disease with a vaccine were published. At the onset of the epidemic, no Ebola vaccine had ever been tried in humans. The swiftness with which efficacy was demonstrated – a critical milestone in the development of any vaccine, which opens up the prospect of its universal use – was unprecedented.

First, WHO had a convening role in coordinating the development of a research and development agenda on Ebola vaccines that was comprehensive and engaged global researchers, ethicists, regulatory bodies, vaccine development and public health partner agencies, industry and the funding community. The WHO Director-General declared the Ebola outbreak in West Africa a Public Health Emergency of International Concern on 8 August 2014. The extent of the outbreak and the difficult progress in its containment made evident the urgent need for a vaccine. By mid-August, through discussions with vaccine researchers in Africa, Europe and North America, WHO had elicited the creation of groups to test two candidate vaccines in Phase I trials (i.e studies that test the safety of a vaccine in humans and the capacity of a vaccine to induce an immune response). WHO also reached out to potential donors to ensure that resources were available to finance these studies. The research groups published the first results of these Phase I studies in November 2014.

At the beginning and at the end of September 2014, WHO convened two consultations that would become the first in a series to assess the efforts under way to fund, evaluate, produce and implement Ebola vaccines. The

September 2014 meetings concluded that Phase I trials should be expedited and their results shared broadly to facilitate rapid progression to Phase II (studies that provide additional proof that a vaccine can induce immunity to an infection). Additionally, these meetings also concluded that three Phase IIb trials (studies to show that a vaccine protects immunized persons against disease) should be conducted in parallel in Ebola-affected countries, including among front line workers or people in communities where Ebola cases have occurred.

Further high-level meetings on Ebola vaccines access and financing were convened in October 2014, January 2015 and May 2015. These initiatives have now evolved into the development of a global strategy and preparedness plan to ensure that targeted research and development can strengthen the emergency response by bringing medical technologies to patients during epidemics. This research and development blueprint will be presented to Member States at the Health Assembly in May 2016.

Secondly, WHO had a leadership role in forming a consortium that designed a vaccine efficacy trial (Phase III) and implemented it in Guinea. At the October 2014 Ebola vaccine meeting, it became apparent that, despite the interest of the national authorities, no international research institution was interested in carrying out vaccine trials in Guinea. WHO immediately assembled a team of researchers, who devised an innovative design to test vaccine efficacy based on the experience of the 1960–1970s smallpox eradication initiative. This trial was based on the vaccination of clusters of people ("rings") who had potentially been in contact with new Ebola patients. Although logistically onerous to carry out because it requires quick deployment of vaccination teams every time a new case is reported, the design would prove to be very efficient because it allowed assessment of vaccine efficacy even against a backdrop of greatly decreased Ebola virus transmission.

Based on criteria established in a previous Ebola vaccine consultation, the candidate vaccine rVSV-ZEBOV (developed originally by the Public Health Agency of Canada and currently by the vaccine manufacturer Merck) was selected for the Guinean trial. After ensuring the necessary ethical approvals and preparing the personnel and logistics for the field implementation, more than 8000 people in over 100 rings were vaccinated between March and October 2015. Preliminary results published in July 2015 showed that the rVSV-ZEBOV vaccine is 100% efficacious and that its use in a ring vaccination strategy was most likely effective at the population level. As of February 2016, these results are the only ones available on the efficacy of any Ebola candidate vaccine and are pivotal in leading to licensure of the rVSV-ZEBOV vaccine. Overall, the Guinean Ebola vaccine ring trial demonstrates WHO's capacity, in collaboration with experts, to devise innovative approaches to health research and interventions and to implement them efficiently even during emergencies and under the most challenging conditions.

The trial consortium led by WHO includes the Ministry of Health of Guinea, Médecins sans Frontières, EPICENTRE, and the Norwegian Institute of Public Health. The trial is funded by WHO, with support from the Wellcome Trust, the Department for International Development of the United Kingdom of Northern Ireland and Great Britain, the Norwegian Ministry of Foreign Affairs to the Norwegian Institute of Public Health through the Research Council of Norway, the Canadian Government (through the Public Health Agency of Canada, Canadian Institutes of Health Research, the International Development Research Centre and the Department of Foreign Affairs, Trade and Development), and Médecins sans Frontières.

In parallel with the clinical development of an Ebola vaccine, WHO has also had a critical role in developing guidance and capacity for a potential Ebola vaccine roll-out. Under WHO leadership, a Global Ebola Vaccine Implementation Team (GEVIT) was created in February 2015 to support affected countries in the planning of large-scale vaccine introduction in accordance with WHO recommendations. GEVIT currently brings together the West African countries most affected by the 2014–2015 Ebola epidemics and key partners – the Bill and Melinda Gates Foundation, the United States Centers for Disease Control and Prevention, the GAVI Alliance, UNICEF, USAID, and WHO. Overseen by a steering group, GEVIT is organized into three working groups: (i) country implementation; (ii) monitoring, surveillance and impact evaluation; and (iii) vaccine supply, allocation and procurement.

GEVIT has produced country guidance for vaccination activities during the 2014–2015 Ebola outbreak and as a response to future outbreaks of other epidemic-prone infectious diseases as well as guidance for monitoring activities during vaccine deployment. But equally importantly, the GEVIT process has also led to the development of models of supply capacity and timing of availability based on different potential demand scenarios, to the establishment of an International Coordinating Group for a global emergency stock of Ebola vaccine, and to the definition of Ebola vaccine procurement modalities. Because of the interruption of Ebola

virus transmission, the focus of GEVIT has now been redirected towards the development of generic contingency plans for future outbreaks.

Finally, WHO is also leveraging its longstanding role in making global immunization recommendations that underpin immunization policies, specifically through the Strategic Advisory Group of Experts (SAGE) on immunization. Established in 1999, SAGE is the principal advisory group to WHO on vaccines and immunization. It is charged with advising WHO on overall global policies and strategies, ranging from vaccines and technology, research and development, to delivery of immunization and its linkages with other health interventions. SAGE was presented with updates on Ebola occurrence in West Africa and on vaccine development in its meetings of October 2014 and April 2015. In October 2015, SAGE reviewed in detail the following aspects: available information on epidemiology, risk factors and transmission patterns of Ebola virus disease; the status of vaccine development; preliminary results from the most advanced vaccine candidates; preparations for vaccine deployment; and projections of the impact of vaccination in different epidemiological scenarios. Based on these data, SAGE made four provisional vaccination recommendations that are not specific to any particular Ebola vaccine in development and that will be revised when additional data become available. SAGE also outlined 10 additional areas for data review or research.

Overall, these vaccine development activities were unprecedented in speed and demonstrated the ability of WHO to convene and steer a large number of outside partners as well as multiple contributing internal departments in the same direction.

The above is an illustration of the work that has been done for programme area on vaccine-preventable diseases. The above is a solid example of one of WHO's six core functions namely "Providing leadership on matters critical to health and engaging in partnerships where joint action is needed".

The table below shows overall output achievements by major office. For more detailed information on the work implemented under this programme area, including explanations of output ratings, please consult the programme budget web portal.[1]

(✓)Fully delivered/contributed (!) Partly delivered/contributed (X) Not delivered/contributed (n/a) Not applicable								
Output		**Africa**	**Americas**	**South-East Asia**	**Europe**	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**
1.5.1.	Implementation and monitoring of the global vaccine action plan as part of the Decade of Vaccines Collaboration strengthened with emphasis on reaching the unvaccinated and under-vaccinated populations	✓	✓	✓	✓	✓	✓	✓
1.5.2.	Intensified implementation and monitoring of measles and rubella elimination, and hepatitis B control strategies facilitated	✓	✓	✓	✓	✓	✓	✓
1.5.3.	Target product profiles for new vaccines and other immunization-related technologies defined and research priorities to develop vaccines of public health importance and overcome barriers to immunization agreed	✓	!	✓	n/a	✓	✓	✓

[1] Available at http://extranet.who.int/programmebudget/Biennium2016/Programme/Overview/159, accessed 7 April 2016.

Budget and expenditure by major office, 2014–2015 (US$ 000)

	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Health Assembly-approved budget	163 200	9300	40 800	12 300	39 300	26 100	55 800	346 800
Funds available (as at 31 December 2015)								
Flexible funds	17 231	3233	3821	842	3171	1960	6730	36 988
Voluntary contributions specified	106 062	10 811	19 347	12 372	22 410	20 165	58 814	250 008
Total	**123 293**	**14 044**	**23 168**	**13 214**	**25 581**	**22 125**	**65 544**	**286 996**
Funds available as a % of budget	76%	151%	57%	107%	65%	85%	117%	83%
Staff costs	26 443	7997	5441	4688	5987	7081	30 362	87 999
Activity costs	81 768	5798	15 888	7 929	18 353	13 295	25 130	168 161
Total expenditure	**108 211**	**13 795**	**21 329**	**12 617**	**24 340**	**20 376**	**55 492**	**256 160**
Expenditure as a % of approved budget	66%	148%	52%	103%	62%	78%	99%	74%
Expenditure as a % of funds available	88%	98%	92%	95%	95%	92%	85%	89%
Staff expenditure by major office	30%	9%	6%	5%	7%	8%	35%	100%

Category 2

NONCOMMUNICABLE DISEASES

With the advent of the Sustainable Development Goals, there came a renewed push to tackle noncommunicable diseases, which are included as a specific target in the Sustainable Development Goals (reducing premature mortality from noncommunicable diseases by one third) and are part of several other health-related targets. This increased emphasis on noncommunicable diseases is part of the journey that started with the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases adopted at the General Assembly in 2011.

In 2013, the Health Assembly endorsed the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2030. . In 2014, during the second United Nations High-level Meeting on Noncommunicable Diseases, governments prioritized four time-bound commitments for 2015 and 2016 in preparation for the third such meeting, to take place in 2018.

To track the extent to which the 194 Member States of WHO are implementing these four time-bound commitments, WHO published the first WHO Noncommunicable Diseases Progress Monitor in September 2015, which includes 18 concrete measures for governments to take to fulfil their promises made in 2014. Despite the current, unprecedented level of strengthening of national noncommunicable disease responses, the Monitor demonstrated that if the current level of strengthening is simply maintained, progress will not be sufficient to fulfil the promise made by governments in 2014.

The above illustrates that, while there is political commitment to accelerate action to address noncommunicable diseases, too many countries, unfortunately, have not translated their 2014 commitments into tangible action.

WHO reported to its Executive Board in January 2016 that the probability of dying between the ages of 30 and 70 years from one of the major noncommunicable diseases has started to decline since 2011, as has exposure to some risk factors, such as the prevalence of current tobacco use among persons aged 18 years and older, the prevalence of raised blood pressure among persons aged 18 years and older, and alcohol per capita consumption. Similarly, the number of countries that have operational noncommunicable disease units within their ministry of health has started to increase.

Such progress has inspired WHO to assert that the global target to reduce premature mortality from noncommunicable diseases by one third by 2030 can be attained. The next two years of the noncommunicable disease response must take into account the findings of the WHO Noncommunicable Disease Monitor 2015, reaching countries being left behind and capitalizing on the opportunities provided by the Sustainable Development Goals. The Goals give governments a mandate to take the noncommunicable disease response out of its isolation and unleash its potential to deliver on global collective action and collaboration to, at the same time, address mental health and substance abuse, disability, violence and injury prevention, and nutrition.

To address this challenge at country level, WHO is developing an acceleration framework to provide a systematic way for Member States to develop their own action plans for these areas, based on existing plans and processes, so as to meet their national priorities and targets. The framework has gathered evidence on obstacles to progress and gives suggestions on how to overcome them. This evidence reveals that there is a range of tried and tested policies which, adapted to national contexts, will ensure progress if there is leadership, capacity, funding and multisectoral and multistakeholder coordination to implement them.

Member States around the world have a window of opportunity – of 24 months or less – in which to scale up before the 2018 UN High-level meeting. Action now will bring future savings of lives and resources.

CATEGORY 2 OVERALL FINANCIAL SUMMARY, 2014–2015 (US$ 000)

	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Health Assembly-approved budget	56 500	21 700	21 800	32 800	23 500	42 100	119 500	317 900
Funds available (as at 31 December 2015)								
Flexible funds	28 991	12 061	14 370	9427	12 393	16 624	51 265	145 131
Voluntary contributions specified	21 056	3787	3612	12 490	2827	16 764	53 243	114 600
Total	**50 047**	**15 848**	**17 982**	**21 917**	**15 220**	**33 388**	**104 508**	**259 731**
Funds available as a % of budget	89%	73%	82%	67%	65%	79%	87%	82%
Staff costs	23 127	7877	6755	9713	6222	12 182	60 843	126 719
Activity costs	22 263	7741	10 154	10 570	9003	20 216	30 931	110 878
Total expenditure	**45 390**	**15 618**	**16 909**	**20 283**	**15 225**	**32 398**	**91 774**	**237 597**
Expenditure as a % of approved budget	80%	72%	78%	62%	65%	77%	77%	75%
Expenditure as a % of funds available	91%	99%	94%	93%	100%	97%	88%	91%
Staff expenditure by major office	18%	6%	5%	8%	5%	10%	48%	100%

2.1 NONCOMMUNICABLE DISEASES

OUTCOME 2.1. INCREASED ACCESS TO INTERVENTIONS TO PREVENT AND MANAGE NONCOMMUNICABLE DISEASES AND THEIR RISK FACTORS

Preventing people from dying too young from noncommunicable diseases

The landmark 2000 WHO Global Strategy for the Prevention and Control of noncommunicable diseases continues to inspire the world. Globally, the probability of dying prematurely from one of the four main noncommunicable diseases fell by 15% between 2000 and 2012. Age-standardized cardiovascular disease death rates fell by 16% globally between 2000 and 2012 and have decreased in every region. Cancer mortality has seen a 6% reduction in age-standardized rates during 2000–2012. Progress in chronic respiratory diseases has been impressive, with a 26% decline in estimated age-standardized mortality rates between 2000 and 2012. The global prevalence of tobacco smoking among people aged 15 years and older has declined from 27% in 2000 to 21% in 2013. Particularly significant declines have occurred in high-income OECD countries.

This progress inspired world leaders in 2011 to agree at a high-level meeting organized under the auspices of WHO at the United Nations General Assembly that much more could be done to reach people left behind in other countries and reduce premature mortality from noncommunicable diseases. The Political Declaration on Noncommunicable Diseases adopted at the high-level meeting is a bold commitment from world leaders brokered by WHO to create a world which will be very different from the one we know today. It will be a world in which noncommunicable diseases are no longer hidden, misunderstood and under recorded; where all eligible people receive drug therapy and counselling to prevent heart attacks and strokes; where all people, regardless of their income, have access to safe, affordable, effective and quality medicines and technologies to diagnose and treat cancer and diabetes; where young people are protected from the risks and consequences of tobacco use; where all people, regardless of where they live of who they are, have access to affordable food products consistent with a healthy diet and that follow nutrition facts and labelling standards, including information on sugars, salts, fats and trans-fat content.

Since the Declaration was endorsed in 2011, WHO has been deeply involved in rallying ministries, United Nations agencies and civil society organizations behind these commitments to create a world where no one is left behind. In 2014 and 2015, WHO brought its programming experience in noncommunicable diseases to bear in supporting many countries to develop their national noncommunicable disease responses. In Samoa, WHO supported the Ministry of Health, the National Health Service and women's groups to implement the WHO Package of Essential Noncommunicable Disease Interventions (PEN) in villages across the country. PEN in Samoa has three main pillars: early detection of noncommunicable diseases, noncommunicable disease management and increased community awareness, and builds on existing community structures. In Mongolia, WHO and the United States Millennium Challenge Corporation supported the Nutrition Division of the National Centre for Public Health in developing and rolling out a project to lower the use of salt in the food industry. As a result of the Salt Pinch, people reduced their daily salt intake by almost 2 grams. In Argentina, WHO helped the Ministry of Health broker a similar public–private partnership with the Argentine Federation of Baked Products Industries. In Barbados, WHO supported the development of a plan aimed at preventing childhood obesity and implementing a 10% tax on sugar-sweetened beverages. In Senegal, WHO supported the ministries of health and telecommunications to roll out a free mobile phone text messaging service, which helps people with diabetes to avoid complications triggered by fasting and feasting during Ramadan. WHO supported similar initiatives that use mobile technology, in particular text messaging and apps, for tobacco cessation and cervical cancer in Costa Rica and Zambia. Regional physical activity strategies and frameworks have been developed by the WHO European and Eastern Mediterranean regions.

In Benin, the Democratic Republic of the Congo and Jordan, WHO supported the implementation of MPOWER[1] measures in line with the provisions of the WHO Framework Convention on Tobacco Control, leading to the establishment of national coordination mechanisms. In Gambia, WHO supported the Ministry of Finance to reform tax policy, which led to substantive excise tax increases on tobacco products in 2015. In China, WHO helped reform the tax policy on cigarettes, leading to a price increase of the cheapest brands by as much as 20%. This reform was also significant because it established an important precedent that increases in cigarette taxes should be passed on to the retail price, thus facilitating the intended public health impact via reduced tobacco consumption. In Kenya, WHO supported the Government to reform the tobacco tax structure and raise tobacco taxes with a decline in consumption of 16% and an increase in tax revenues of 29%.

Inspired by these success stories from WHO, and building on four game-changing, time-bound commitments which ministers of health and foreign affairs made at the United Nations General Assembly in 2014 to accelerate national noncommunicable disease responses, world leaders asserted in 2015 that a global Sustainable Development Goal target to reduce premature mortality from noncommunicable diseases by one third by 2030 can be attained. Their decision to leave no one behind in the response will profoundly affect the entire lifespan of millions of people around the world, for generations to come. The post-2030 world will be very different from the one we know today – and it is one WHO will continue to help to create.

In India, WHO supported the Government to become the first in the world to develop specific national targets for noncommunicable diseases, to be attained in 2025, and to develop a national multisectoral action plan to attain those targets, engaging stakeholders across the Government, nongovernmental organizations, civil society and the private sector. In Nepal, WHO helped the Government to continue care for diabetes and heart patients in earthquake-hit facilities. In Bhutan, WHO supported the Ministry of Health in addressing hypertension, heart disease and diabetes among women in mountain villages. In Jordan, WHO supported the Ministry of Health and nongovernmental organizations to enable health systems to respond to the health care needs of registered refugees with noncommunicable diseases from the Syrian Arab Republic hosted by Jordan. In Mexico, WHO supported the Government in developing a programme to ensure that all women diagnosed with breast cancer can be treated.

We have never had more opportunities to leverage the momentum to accelerate the noncommunicable disease response over the next two years: a bold noncommunicable disease target from world leaders which sits squarely within the new Agenda for Sustainable Development, four time-bound commitments made by ministers in 2014, the game-changing political foundations agreed upon by world leaders in 2011, the rise of regional and national noncommunicable disease leadership and political institutions since then, and a decision to hold the third United Nations General Assembly High-level Meeting on Noncommunicable Diseases in 2018 to review progress made and agree on a new set of prioritized targets for the next milestone on the way to 2030.

The countdown to 2018 has begun. A world free of the avoidable burden of noncommunicable diseases – in which no one will be left behind – is achievable.

The above is an illustration of the work that has been done under the programme area on noncommunicable diseases. The support WHO is providing to a large number of countries to help implement evidence-based and well-documented interventions is a substantial contribution to reaching the noncommunicable disease outcome indicators related to reductions in the harmful use of alcohol, tobacco use, raised blood pressure, salt intake, and diabetes and obesity.

The table below shows overall output achievements by major office. For more detailed information on the work implemented under this programme area, including explanations of output ratings, please consult the programme budget web portal.[2]

[1] **M**onitor tobacco use and prevention policies, **P**rotect people from tobacco smoke, **O**ffer help to quit tobacco use, **W**arn about the dangers of tobacco, **E**nforce bans of tobacco advertising, promotion and sponsorship, **R**aise taxes on tobacco.

[2] Available at http://extranet.who.int/programmebudget/Biennium2016/Programme/Overview/160, accessed 7 April 2016.

(✓)Fully delivered/contributed (!) Partly delivered/contributed (X) Not delivered/contributed (n/a) Not applicable								
Output		Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
2.1.1.	Development of national multisectoral policies and plans for implementing interventions to prevent and control noncommunicable diseases facilitated	✓	!	✓	✓	!	✓	✓
2.1.2.	High-level priority given to the prevention and control of noncommunicable diseases in national health planning processes and development agendas	✓	!	✓	✓	!	✓	✓
2.1.3.	Monitoring framework implemented to report on progress in realizing the commitments made in the Political Declaration of the High-Level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and the global action plan for the prevention and control of noncommunicable diseases (2013–2020)	✓	✓	✓	✓	!	✓	✓

Budget and expenditure by major office, 2014–2015 (US$ 000)

	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Health Assembly-approved budget	48 000	13 200	15 900	16 400	16 300	28 200	54 100	192 100
Funds available (as at 31 December 2015)								
Flexible funds	24 052	6103	9753	4917	7616	11 094	27 420	90 955
Voluntary contributions specified	5830	1407	2529	6861	1071	8636	16 852	43 186
Total	**29 882**	**7510**	**12 282**	**11 778**	**8687**	**19 730**	**44 272**	**134 141**
Funds available as a % of budget	62%	57%	77%	72%	53%	70%	82%	70%
Staff costs	18 646	4244	4496	5339	3797	7397	25 506	69 425
Activity costs	9889	3226	6969	5095	4816	11 678	13 663	55 336
Total expenditure	**28 535**	**7470**	**11 465**	**10 434**	**8613**	**19 075**	**39 169**	**124 761**
Expenditure as a % of approved budget	59%	57%	72%	64%	53%	68%	72%	65%
Expenditure as a % of funds available	95%	99%	93%	89%	99%	97%	88%	93%
Staff expenditure by major office	27%	6%	6%	8%	5%	11%	37%	100%

2.2 MENTAL HEALTH AND SUBSTANCE ABUSE

OUTCOME 2.2. INCREASED ACCESS TO SERVICES FOR MENTAL HEALTH AND SUBSTANCE USE DISORDERS

From guidelines to country reality

Worldwide, 14% of the global burden of disease can be attributed to mental, neurological and substance use disorders. While nearly 1 in 10 people have a mental health disorder, only 1% of the global health workforce is working in mental health. To provide normative guidance and tools and facilitate the scaling up of care for mental, neurological and substance use disorders in low- and middle-income countries, WHO initiated the Mental Health Gap Action Programme (mhGAP).

The mhGAP package consists of interventions for prevention and management of priority mental, neurological and substance use conditions identified on the basis of their high burden, large economic costs or because of their association with violations of human rights. These priority conditions are depression, psychoses, suicide, epilepsy, dementia, disorders due to use of alcohol, disorders due to use of illicit drugs and mental disorders in children.

Evidence-based mhGAP guidelines, developed following the WHO guideline development methodology, form the technical core of the intervention guide (mhGAP-IG). The programme has been developed through the participation of international panels of experts and institutions with multidisciplinary expertise from all WHO regions. The mhGAP guidelines were developed in 2009 and have been regularly updated and expanded (last revised in 2015). The target audience consists of non-specialized health care providers working in first- and second-level health care facilities in low- and middle-income countries. These could be primary care doctors, nurses or other members of the health care workforce.

Currently, mhGAP is being used in 90 countries in all WHO regions and mhGAP materials have been translated into 19 languages, including the six official United Nations languages.

The development and implementation of the mhGAP package has been a best practice for the division of labour across the three levels of the Organization. While WHO headquarters has provided normative guidance and tools, the regional and country offices have led their regional adaptation and wide-scale implementation.

Below are some examples of current mhGAP use.

- Scaling up mental health services and reducing the treatment gap - In Ethiopia, mhGAP is used as an essential component of the National Mental Health Strategy 2012–2016 to deliver comprehensive and integrated community-based services, for example in Sodo district, Gurage zone. Through the training of 119 nurses and 92 health workers using mhGAP-IG, service coverage for people with psychotic disorders is now reaching 80% in these areas. A programme on reducing the epilepsy treatment gap is currently being implemented with thousands of beneficiaries in Ghana, Mozambique, Myanmar and Viet Nam. In Ghana, there is project coverage of approximately 1.2 million people across 10 districts. The epilepsy treatment gap has been reduced by 30% in the last four years. In Myanmar, with project coverage of 1.4 million people across eight townships, the epilepsy treatment gap has been reduced on average by 38% over the last three years.
- mhGAP used for curriculum development for health professionals - mhGap has been used to update undergraduate training in Mexico for medical doctors, implemented by Madrid University; to develop a postgraduate diploma in primary mental health care in Libya (in collaboration with the National Centre for Disease Control in Tripoli and the WHO Country Office in Libya); and to update the undergraduate curriculum in Somalia (Amoud and Hargeisa University in collaboration with King's College London).
- Collaboration and partnerships for implementation - It is not only ministries of health that are using the mhGAP package to scale up mental health care; a range of other stakeholders, including WHO collaborating centres, United Nations agencies, professional associations, and national and international nongovernmental organizations and foundations, are utilizing mhGAP guidance and tools. The European Union has funded mhGAP implementation at several sites such as the West Bank and Gaza Strip, Nigeria and Ethiopia. Grand Challenges Canada funded 13 projects using mhGAP materials in 11 countries in four

WHO regions. The Programme for Improving Mental Health Care (PRIME), which is supported by the Department for International Development of the United Kingdom of Great Britain and Northern Ireland, aims to improve the coverage of treatment for priority mental disorders by implementing and evaluating the mhGAP guidelines in five countries (Ethiopia, India, Nepal, South Africa and Uganda).

- mhGAP use in emergencies. In emergencies, the population's needs for services may overwhelm existing capacity and resources - During and after the public health emergency caused by the Ebola virus disease outbreak, mhGAP was used to scale up services to Ebola survivors and their caregivers through the WHO country offices in Guinea, Liberia and Sierra Leone. In the Philippines, mhGAP was used to integrate mental health care into all health services across a region of 4 million people badly affected by typhoon Haiyan. In the Syrian Arab Republic, following capacity building of more than 500 health professionals, mhGAP is now being used to provide services at primary health care level in more than 10 Syrian governorates, including the most affected areas of the current conflict. In 2015, 18% of the functioning primary and secondary health care centres in the Syrian Arab Republic offered mental health care for the first time, as a result of the mhGAP programme.

The description of the implementation of the mhGAP guidelines is a clear demonstration of the stages of a programme from development of norms and standards to country action. It also describes the unique contribution of each of the three levels of the Organization. The results of mhGAP implementation contribute to the outcome indicators of increased service provision for persons with severe mental disorders and the reduction of suicide.

The table below shows overall output achievements by major office. For more detailed information on the work implemented under this programme area, including explanations of output ratings, please consult the programme budget web portal.[1]

(✓)Fully delivered/contributed (!) Partly delivered/contributed (X) Not delivered/contributed (n/a) Not applicable

Output		Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
2.2.1.	Countries' capacity to develop and implement national policies and plans in line with the 2013–2020 global mental health action plan strengthened	✓	!	✓	✓	✓	✓	✓
2.2.2.	Mental health promotion, prevention, treatment and recovery services improved through advocacy, better guidance and tools on integrated mental health services	✓	✓	✓	✓	✓	✓	✓
2.2.3.	Expansion and strengthening of country strategies, systems and interventions for disorders due to alcohol and substance use enabled	✓	X	✓	✓	✓	✓	✓

[1] Available at http://extranet.who.int/programmebudget/Biennium2016/Programme/Overview/161, accessed 7 April 2016.

Budget and expenditure by major office, 2014–2015 (US$ 000)

	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Health Assembly-approved budget	2300	2600	1400	7200	2800	4300	18 600	39 200
Funds available (as at 31 December 2015)								
Flexible funds	1765	1741	1190	2606	1998	2131	7775	19 206
Voluntary contributions specified	624	16	305	1660	0	1117	11 124	14 846
Total	**2389**	**1757**	**1495**	**4266**	**1998**	**3248**	**18 899**	**34 052**
Funds available as a % of budget	104%	68%	107%	59%	71%	76%	102%	87%
Staff costs	661	1028	557	2172	869	1228	11 246	17 761
Activity costs	1006	736	915	1980	1116	1868	5444	13 065
Total expenditure	**1667**	**1764**	**1472**	**4152**	**1985**	**3096**	**16 690**	**30 826**
Expenditure as a % of approved budget	72%	68%	105%	58%	71%	72%	90%	79%
Expenditure as a % of funds available	70%	100%	98%	97%	99%	95%	88%	91%
Staff expenditure by major office	4%	6%	3%	12%	5%	7%	63%	100%

2.3 VIOLENCE AND INJURIES

OUTCOME 2.3. REDUCED RISK FACTORS FOR VIOLENCE AND INJURIES WITH A FOCUS ON ROAD SAFETY, CHILD INJURIES, AND VIOLENCE AGAINST CHILDREN, WOMEN AND YOUTH

Sustainable Development Goals encourage urgent intervention on road safety

Leading to 1.25 million deaths every year and between 20–50 million non-fatal injuries, and costing governments between 3% and 5% of their gross domestic product, road traffic accidents are finally being given more of the priority they deserve. The year 2015 was a particularly critical year for road safety, both because of the number of high-profile activities held, and because it represents a culmination of concerted efforts over more than a decade to save lives on the world's roads. Since the release of the WHO and World Bank *World report on road traffic injury prevention* in 2004, there has been a change of recognition, with road traffic crashes now rightfully considered a major health and development concern.

With this recognition has come action, and a hint of good news to come. After more than a century of increases in mortality, WHO's *Global status report on road safety 2015* shows a plateau in the number of road traffic deaths globally as compared to three years earlier. The African Region continues to have the highest road traffic death rates, while the lowest rates are in the European Region. Despite progress, the report highlights the need to address the issue in a holistic "safe systems" approach, thereby focusing not only on user behaviour, but also on the other components of the system, namely safe infrastructure and safe vehicles. Since around half of all deaths occur among those outside a vehicle, i.e. pedestrians, cyclists and motorcyclists, more focus needs to be placed on rethinking, in particular, urban settings to better protect these vulnerable road users.

In September 2015, another milestone was achieved. Building on the efforts of WHO and many partners, road safety was included in two of the Sustainable Development Goals – Goal 3 on health and Goal 11 on sustainable cities and communities. Target 3.6 – to halve the number of global deaths and injuries from road traffic crashes – is very ambitious and is one of only a handful of targets with a 2020 end date. This means that in five years, approximately 600 000 deaths need to be averted around the world. This will require substantially increased and concerted effort from multisectoral agencies, governments, international agencies, civil society and the private sector. In this context, WHO is working with international partners to develop a package of core interventions which will assist Member States to put in place both effective and cost-efficient strategies to more rapidly address the problem.

The Second Global High-Level Conference on Road Safety, hosted by the Government of Brazil and co-sponsored by WHO in November 2015, served as an opportunity to engage with policy-makers at the highest level to chart ways to fulfil the ambitious target set by the Sustainable Development Goals. The Brasilia Declaration, which calls on all countries to step up road safety activities, was adopted. A United Nations General Assembly resolution and a Health Assembly resolution are likely to endorse the recommendations of this declaration in 2016.

While these political processes help to drive action, the true test of their power rests with their ability to affect change in countries. This is manifested through the adoption and enforcement of legislation around speeding, drinking and driving, and the use of motorcycle helmets, seat-belts and child restraints; improvements in the safety of roads and vehicles; and enhancements in trauma care. During this and the previous biennium, WHO, in collaboration with partners, has been able to help achieve and demonstrate substantial gains in countries. These include reductions in speeding and increases in seat-belt wearing in the Russian Federation and Turkey; and reductions in drinking and driving and increases in motorcycle helmet wearing in Cambodia and Viet Nam, among others.

Under the banner of the Decade of Action for Road Safety 2011–2020, which was declared by the United Nations General Assembly in 2010, WHO will focus on providing technical support to Member States to implement and monitor good road safety practices, while continuing to act as the coordinator of road safety within the United Nations system together with the United Nations regional commissions.

The above is an illustration of the work that has been done under the programme area on violence and injuries. All the actions that have been undertaken over the years by WHO and partners to alert the world to road safety can now be seen (as documented in WHO's *Global status report on road safety 2015*) to be contributing to the outcome of reducing mortality from traffic accidents.

The table below shows overall output achievements by major office. For more detailed information on the work implemented under this programme area, including explanations of output ratings, please consult the programme budget web portal.[1]

[1] Available at http://extranet.who.int/programmebudget/Biennium2016/Programme/Overview/162, accessed 7 April 2016.

(✓)Fully delivered/contributed (!) Partly delivered/contributed (X) Not delivered/contributed (n/a) Not applicable								
Output		Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
2.3.1.	Development and implementation multisectoral plans and programmes to prevent injuries, with a focus on achieving the targets set under the Decade of Action for Road Safety (2011–2020)	!	!	✓	✓	✓	✓	!
2.3.2.	Countries and partners enabled to develop and implement programmes and plans to prevent child injuries	✓	n/a	✓	✓	✓	✓	!
2.3.3.	Development and implementation of policies and programmes to address violence against women, youth and children facilitated	✓	!	✓	✓	✓	✓	✓

Budget and expenditure by major office, 2014–2015 (US$ 000)

	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Health Assembly-approved budget	1400	2200	900	6700	1000	4200	14 700	31 100
Funds available (as at 31 December 2015)								
Flexible funds	789	1383	1732	1093	820	1350	4920	12 087
Voluntary contributions specified	1136	1686	710	2316	193	3191	9516	18 748
Total	**1925**	**3069**	**2442**	**3 409**	**1013**	**4541**	**14 436**	**30 835**
Funds available as a % of budget	138%	140%	271%	51%	101%	108%	98%	99%
Staff costs	590	1532	954	1340	583	1179	9604	15 782
Activity costs	1010	1504	1229	2073	348	3216	3842	13 222
Total expenditure	**1600**	**3036**	**2183**	**3413**	**931**	**4395**	**13 446**	**29 004**
Expenditure as a % of approved budget	114%	138%	243%	51%	93%	105%	91%	93%
Expenditure as a % of funds available	83%	99%	89%	100%	92%	97%	93%	94%
Staff expenditure by major office	4%	10%	6%	8%	4%	7%	61%	100%

2.4 DISABILITIES AND REHABILITATION

OUTCOME 2.4. INCREASED ACCESS TO SERVICES FOR PEOPLE WITH DISABILITIES

Establishing WHO leadership in the field of hearing care: a case study

"A regular runner, Matthew Brady enjoyed listening to music through his headphones while he was on his treadmill every day. Unaware of the impact of loud sounds on his ears, he turned up the volume such that even his parents sitting downstairs could hear his music. When he started having trouble in hearing what was being spoken around him, he became concerned. The problem was considerably more marked in places with high background noise, such as restaurants. To compensate for his hearing loss, he also started speaking loudly. After months of seeking professional help, he was diagnosed with permanent hearing loss, as a consequence of the damage to the fine structures within his ear from the high volume. Today, Matthew has learnt to live with his hearing loss, and manages with the help of lip-reading. He has changed his listening habits to prevent further hearing damage and is an advocate for prevention of hearing loss through raised awareness and safe listening practices."

Matthew shared his story at a WHO consultation in October 2015. It highlights the risk faced by over 1 billion adolescents and young adults due to regular or prolonged exposure to high volumes at entertainment venues and through the improper use of their personal audio systems (music players and head/earphones).

Globally, 360 million people (approximately 5% of the world's population) live with disabling hearing loss, including 32 million children. Hearing loss can result from a variety of causes, many of which are preventable. These include vaccine-preventable infections, birth-related complications, use of ototoxic medicines and exposure to noise, both in recreational and occupational settings. In 2014–2015, among other things, WHO drew its attention on the dangers posed by recreational noise exposure among young people.

In order to effectively anticipate and pre-empt the rising threat of noise-induced hearing loss, WHO launched the Make Listening Safe initiative in March 2015. This initiative was promoted by WHO and partners across the world as the theme for World Hearing Day. Through a seminar, as well as its innovative advocacy materials and media outreach, WHO highlighted the impending epidemic and conveyed the message of safe listening to all stakeholders, including users of personal audio devices, manufacturers and professionals. Partner organizations and press across the world picked up this theme and supported it through social media outreach, press releases, television and radio programmes, and awareness sessions.

In line with its core function of providing leadership and engaging in partnerships, WHO invited all stakeholders to agree on the way forward in the promotion of safe listening. Professionals in the field of hearing health, sound engineers, representatives of professional organizations, manufacturers of personal audio systems and civil society representatives all met in Geneva in October 2015 to develop a cohesive and multifaceted strategy on the subject.

Following up on this initiative, WHO is working on:

- Setting standards for safe listening devices: WHO has collaborated with the International Telecommunications Union to define new global standards for personal audio systems which are consistent with safe listening recommendations. It is expected that devices manufactured in line with these international standards will limit the sound exposure of their users. They will also provide information and messages to promote safe listening practices among users.
- Developing a safe listening software application ("Safe listening app"): this media player will allow its users to play music while monitoring the volume level and time of usage. It will allow users to assess their daily dose of sound and provide warning messages when safe levels are exceeded.

- Developing a standardized screening protocol for recreational noise-induced hearing loss: this protocol will give researchers a standardized tool for collection of data on hearing loss caused by exposure to high volumes in recreational settings and serve as a tool for monitoring future trends.
- Creating safe listening messages: which are to be shared through the device–user interface and which promote a change in listening behaviours.

Overall, WHO's work in the field of prevention of deafness and hearing loss aims to minimize hearing loss due to preventable causes and ensure that those with unavoidable hearing loss can achieve their full potential through rehabilitation, education and empowerment. The focus of this work is on raising awareness on hearing loss and ear diseases, developing evidence-based technical tools and providing technical support to Member States.

The above is an illustration of the work that has been done under the programme area on disabilities and rehabilitation. Putting the focus on hearing care in 2014–2015 is the beginning of a journey whereby several of WHO's core functions will come into play through developing norms and standards, articulating policy options to providing technical support at country level. Overall, over the period covered by the Twelfth General Programme of Work, this will contribute to the outcome of increased access to services for people with hearing disability.

The table below shows overall output achievements by major office. For more detailed information on the work implemented under this programme area, including explanations of output ratings, please consult the programme budget web portal.[1]

(✓)Fully delivered/contributed (!) Partly delivered/contributed (X) Not delivered/contributed (n/a) Not applicable								
Output		**Africa**	**Americas**	**South-East Asia**	**Europe**	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**
2.4.1.	Implementation of the recommendations of the World report on disability and the High-level Meeting of the General Assembly on Disability and Development	✓	✓	!	✓	✓	✓	✓
2.4.2.	Countries are able to strengthen the provision of services to reduce disability due to visual impairment and hearing loss through more effective policies and integrated services	✓	!	✓	n/a	✓	✓	✓

[1] Available at http://extranet.who.int/programmebudget/Biennium2016/Programme/Overview/163, accessed 7 April 2016.

Budget and expenditure by major office, 2014–2015 (US$ 000)

	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Health Assembly-approved budget	900	900	600	500	400	2300	9900	15 500
Funds available (as at 31 December 2015)								
Flexible funds	542	514	326	37	604	525	2872	5420
Voluntary contributions specified	909	90	23	832	274	2995	6549	11 672
Total	**1451**	**604**	**349**	**869**	**878**	**3520**	**9421**	**17 092**
Funds available as a % of budget	161%	67%	58%	174%	220%	153%	95%	110%
Staff costs	566	271	51	227	364	1372	3851	6702
Activity costs	464	283	352	614	427	2145	2672	6957
Total expenditure	**1030**	**554**	**403**	**841**	**791**	**3517**	**6523**	**13 659**
Expenditure as a % of approved budget	114%	62%	67%	168%	198%	153%	66%	88%
Expenditure as a % of funds available	71%	92%	115%	97%	90%	100%	69%	80%
Staff expenditure by major office	8%	4%	1%	3%	5%	20%	57%	100%

2.5 NUTRITION

OUTCOME 2.5. REDUCED NUTRITIONAL RISK FACTORS

Reframing the nutrition debate – an ambitious agenda

The Health Assembly defined the scope of nutrition challenges by committing to achieve, by the year 2025, six global nutrition targets related to reducing stunting and wasting in children under five years of age, halting the rise of obesity, reducing maternal anaemia and low birth weight and increasing breastfeeding. We now acknowledge that the world is affected by multiple forms of malnutrition, that almost no single country is spared, and that the impact on health and development is massive. Unhealthy diet and poor maternal and infant nutrition are leading factors in the global burden of disease.

The Second International Conference on Nutrition (ICN2), jointly convened by FAO and WHO in 2014, indicated that food systems are dysfunctional and governments committed to taking urgent corrective action to ensure that the provision of healthy diets throughout the life-course becomes the main goal of policies and programmes that shape the production, distribution and consumption of food.

The 2030 Agenda for Sustainable Development recognized these approaches and committed to ensuring access for all people to safe, nutritious and sufficient food all year round, to ending all forms of malnutrition, and addressing the nutritional needs of adolescent girls, pregnant and lactating women and older persons. These concepts are strongly embedded in the Global Strategy for Women's, Children and Adolescents' Health, 2016–2030, and in the nutrition work stream of the Committee on World Food Security.

The impact of this policy change is starting to be visible. In all regions and at headquarters, WHO's nutrition work is now fully encompassing the double burden of malnutrition. The regional offices for the Western Pacific,

the Americas and Europe have all recently updated their regional nutrition plans and the regional offices for South-East Asia, the Eastern Mediterranean and Africa have also engaged in this process. Member States have established their own national targets and commitments for nutrition that reflect the full spectrum of malnutrition problems as well as the policy recommendations of ICN2.

WHO is advising countries on policies and programmes that can address the multiple nutrition challenges and provide a clear definition of a healthy diet. WHO published guidelines on sodium and sugars intake and developed a methodology to rate the health impact of foods based on their nutrient content (nutrient profiling). A nutrient profiling system has been developed in the Regional Office for Europe, and others are being developed in the regional offices for South-East Asia, the Eastern Mediterranean and the Western Pacific, as a basis for the development of measures to restrict the marketing of foods to children.

WHO has also developed guidance to address the six global nutrition targets and identified effective nutrition actions that health services should deliver. The WHO global database on the implementation of nutrition action now contains over 1500 policy documents and over 2500 programmes to allow an analysis of the policy response to malnutrition challenges in all countries.

Monitoring the different dimensions of malnutrition and the presence and impact of policies is needed to guide the policy response. The Health Assembly has approved a global nutrition monitoring framework and WHO has developed supportive mechanisms for its implementation, including a technical expert advisory group (jointly with UNICEF).

How do all these different initiatives translate into country action? In the African Region, WHO supported strengthening nutrition monitoring services for over 17% of the districts in 11 countries and trained more than 1600 health workers in nine countries on various aspects of nutrition surveillance, reaching almost 23 million women of reproductive age, and 12 million children under five years of age. WHO also supported nutrition surveillance activities in the European Region and in the Western Pacific Region. In the European Region, a world-leading childhood obesity surveillance initiative has been established, collecting nationally representative, nationally measured and internationally comparable data on overweight and obesity among primary schoolchildren in 31 Member States.

In all major offices the gender, equity and human rights-based approaches have been considered in nutrition programmes. Vulnerable groups, including women, girls and children, have been especially considered, to ensure equity and human rights in all targeted areas and programmes as per Article 25 of the Universal Declaration of Human Rights and Article 11 of the International Covenant on Economic, Social and Cultural Rights. A specific example comes from Western Pacific Region, where weekly iron folic acid supplementation in Lao People's Democratic Republic was particularly designed to target the vulnerable, and in China, where a report on the nutrition situation of left-behind children was produced, which contains recommendations to improve the nutrition situation of children under five years of age in Shaanxi Province.

Moving the overall nutrition agenda ahead, the Sustainable Development Goals provide unique and unprecedented opportunities for countries to act multisectorally and an important impetus to advance nutrition globally. For WHO to fully exercise its role in this ambitious agenda requires collaborative work across technical areas and the engagement of all three levels of the Organization.

The work on nutrition in 2014–2015, with the articulation of and agreement on six global nutrition targets, has set the scene for improved monitoring and assessment in progress towards the outcome indicators related to nutritional risk factors. Setting norms and standards and monitoring health trends over time, as articulated in WHO core functions, remain a sound basis for WHO's work.

The table below shows overall output achievements by major office. For more detailed information on the work implemented under this programme area, including explanations of output ratings, please consult the programme budget web portal.[1]

[1] Available at http://extranet.who.int/programmebudget/Biennium2016/Programme/Overview/164, accessed 7 April 2016.

(✓)Fully delivered/contributed (!) Partly delivered/contributed (X) Not delivered/contributed (n/a) Not applicable								
Output		**Africa**	**Americas**	**South-East Asia**	**Europe**	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**
2.5.1.	Countries enabled to develop, implement and monitor action plans based on the maternal, infant and young child nutrition comprehensive implementation plan	✓	!	✓	✓	✓	!	✓
2.5.2.	Norms and standards on maternal, infant and young child nutrition, population dietary goals, and breastfeeding updated, and policy options for effective nutrition actions for stunting, wasting and anaemia developed	✓	!	✓	✓	✓	!	✓

Budget and expenditure by major office, 2014–2015 (US$ 000)

	Africa	**Americas**	**South-East Asia**	**Europe**	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**	**Total**
Health Assembly-approved budget	3900	2800	3000	2000	3000	3100	22 200	40 000
Funds available (as at 31 December 2015)								
Flexible funds	1843	2320	1369	774	1355	1524	8278	17 463
Voluntary contributions specified	12 557	588	45	821	1289	825	9202	26 148
Total	**14 400**	**2908**	**1414**	**1595**	**2644**	**2349**	**17 480**	**43 611**
Funds available as a % of budget	369%	104%	47%	80%	88%	76%	79%	109%
Staff costs	2664	802	697	635	609	1006	10 636	17 049
Activity costs	9894	1992	689	808	2296	1309	5310	22 298
Total expenditure	**12 558**	**2794**	**1386**	**1443**	**2905**	**2315**	**15 946**	**39 347**
Expenditure as a % of approved budget	322%	100%	46%	72%	97%	75%	72%	98%
Expenditure as a % of funds available	87%	96%	98%	90%	110%	99%	91%	90%
Staff expenditure by major office	16%	5%	4%	4%	4%	6%	62%	100%

Category 3

PROMOTING HEALTH THROUGH THE LIFE-COURSE

This category brings together strategies for promoting health and well-being from conception to old age. Its work is by nature cross-cutting and addresses population needs with a special focus on key stages in life. The life-course approach considers how multiple determinants interact and affect health.

The work undertaken in this category has had a direct link to, and contributed towards, agreed international goals such as Millennium Development Goals 4 (Reduce child mortality) and 5 (Improve maternal health). While much has been achieved there are still tremendous challenges yet to overcome, and WHO's work will be delivered in the context of the new global development agenda.

A comprehensive set of targets for addressing the health and well-being of women, children and adolescents has been adopted under the Sustainable Development Goals. Ambitious targets are set to end preventable maternal and child deaths and achieve universal access to reproductive health care services.

The United Nations Secretary-General's new Global Strategy for Women's, Children's, and Adolescents' Health, 2106–2030, provides a multistakeholder framework for the implementation, follow-up and monitoring of progress towards the related targets.

The Sustainable Development Goals include several targets relating to environmental sustainability and human health. Noteworthy for poverty reduction is the consideration that environmental risks such as the use of solid fuels and unsafe water and sanitation disproportionally affect the poor.

CATEGORY 3 OVERALL FINANCIAL SUMMARY, 2014–2015 (US$ 000)

	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Health Assembly-approved budget	92 000	32 200	23 500	40 100	23 100	21 600	156 000	388 500
Funds available (as at 31 December 2015)								
Flexible funds	29 219	15 489	12 780	12 234	12 668	6844	32 815	122 049
Voluntary contributions specified	63 046	2225	8725	18 273	9521	13 613	140 458	255 861
Total	**92 265**	**17 714**	**21 505**	**30 507**	**22 189**	**20 457**	**173 273**	**377 910**
Funds available as a % of budget	100%	55%	92%	76%	96%	95%	111%	97%
Staff costs	32 508	10 241	7687	19 044	8204	8098	77 613	163 395
Activity costs	50 550	7431	11 987	9988	11 845	11 278	73 210	176 289
Total expenditure	**83 058**	**17 672**	**19 674**	**29 032**	**20 049**	**19 376**	**150 823**	**339 684**
Expenditure as a % of approved budget	90%	55%	84%	72%	87%	90%	97%	87%
Expenditure as a % of funds available	90%	100%	91%	95%	90%	95%	87%	90%
Staff expenditure by major office	20%	6%	5%	12%	5%	5%	48%	100%

3.1 REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH

OUTCOME 3.1. INCREASED ACCESS TO INTERVENTIONS FOR IMPROVING HEALTH OF WOMEN, NEWBORNS, CHILDREN AND ADOLESCENTS

Turning the tide on preventable newborn deaths

Nearly 3 million newborn girls and boys take their last breath before reaching one month of age, representing almost half (45%) of global under-five mortality. An additional 2.6 million babies (an almost equal number) are stillborn, about half of such deaths occurring during labour and childbirth.

Most newborn deaths happen in the first week of life. Many could have been prevented, especially if the mother and baby had received adequate quality of care during childbirth, and been followed up with effective postnatal care as recommended, especially in the first week of life. The effective interventions and technologies that protect the lives of newborns exist. Among the most affordable to ensure that newborns survive and thrive include skilled care at birth, essential newborn care (e.g. drying the baby thoroughly, keeping mother and baby together in skin-to-skin contact immediately after birth, and enabling the baby to breastfeed as soon as ready), neonatal resuscitation, exclusive breastfeeding, extra care for small babies (kangaroo mother care,) and management of newborns with signs of severe infections. Not everyone has access to those interventions. Every newborn child has the right to health and well-being, no matter where they are born.

The Every Newborn Action Plan, led by WHO and UNICEF, with support from over 40 partners globally, was developed from the ground up. Prepared through systematic identification of the extreme challenges high-burden countries face, buttressed by state-of-the-art evidence on essential interventions, the Action Plan sets out feasible directives to enable national health plans to provide universal coverage of quality care around the time of birth. The plan ensures that health systems are equipped with life-saving commodities and staffed with health workers with the skills and support to provide quality childbirth care including emergency obstetric care and timely and effective postnatal care, including for small and sickly newborn babies.

The Every Newborn Action Plan was endorsed by 194 countries at the Sixty-eighth World Health Assembly in 2014. Then the real work began, translating words to action in every community, health centre, and health system of each high-burden country. WHO, UNICEF and a host of partners have been steering the Action Plan to save newborn lives through country support, communication of the latest and best evidence to inform action, and measuring impact on the ground. The 18 highest-burden countries have taken concrete action to protect newborn health, and 41 countries have used the recommendations contained in the Action Plan to either strengthen or develop new national health plans on maternal and newborn health.

WHO has reinforced these steps forward with revisions to the clinical practice guides for the integrated management of pregnancy and childbirth, , postpartum and newborn care, the development of new guidelines on treating possible severe bacterial infections when referral is not possible, and the updating of guidelines on care for improving preterm birth outcomes, tools to support quality midwifery care, studies evaluating the effect of vitamin A supplementation on infant survival, the first phase of Better Outcomes in Labour Difficulty, a maternal and newborn mortality and morbidity cohort study, and four new research studies to investigate options for improving the survival of preterm babies. Regional initiatives, such as First Embrace in the Western Pacific Region, also advance progress.

WHO, in collaboration with UNICEF and partners, is now embarking on a global initiative to improve quality of care, which includes provision as well as experience of care, around the time of childbirth. WHO has developed standards that will guide midwifery personnel and health care managers at the front line to provide quality childbirth care.

Communities have an essential role in reducing maternal and neonatal mortality because many deaths and health problems can be avoided through action in the home and village. WHO and partners have developed a training course to guide community mobilization which supplements the WHO/UNICEF package for community health workers – “caring for newborns and children in the community” – that includes modules for the provision of home-based newborn care. A WHO review of the evidence on women’s groups using the Participatory Learning and Action process showed large reductions in newborn deaths in high-mortality rural populations and led to a global policy recommendation.

But much remains to be done. In many settings, newborn babies still do not receive the services they need. Treatment for small and sick babies remains a significant challenge. Not every government has made newborn health a priority and vulnerable health systems can collapse in crises. When Ebola struck West Africa more women and newborns died after childbirth than from the epidemic itself, because of a breakdown in maternal health services.

And new threats can emerge. The Zika virus epidemic in the Americas has spread at an alarming rate and is linked with a surge in the number of newborns with serious brain defects, presumably from infection in early pregnancy. WHO has been coordinating the international response to blunt this mosquito-borne virus epidemic and protect pregnant women in 39 affected countries. Painstaking work on surveillance, data analysis, diagnostics, vaccine candidates and guidelines for health workers is underway.

The momentum created in countries by the WHO/UNICEF-led Every Newborn Action Plan has the potential to contribute substantially to the outcome indicators under this programme area – most specifically to those indicators related to birth attended by skilled health personnel, postnatal care for mothers and babies, and breastfeeding.

The table below shows overall output achievements by major office. For more detailed information on the work implemented under this programme area, including explanations of output ratings, please consult the programme budget web portal.[1]

(✓)Fully delivered/contributed (!) Partly delivered/contributed (X) Not delivered/contributed (n/a) Not applicable								
Output		Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
3.1.1.	Further expansion enabled of access to and quality of effective interventions from pre-pregnancy to postpartum focusing on the 24-hour period around childbirth	✓	!	✓	✓	✓	!	✓
3.1.2.	Countries' capacity strengthened to expand high-quality interventions to improve child health and early child development and end preventable child deaths, including from pneumonia and diarrhoea	✓	!	✓	✓	✓	✓	✓
3.1.3.	Countries enabled to implement and monitor effective interventions to cover the unmet needs in sexual and reproductive health and to reduce adolescent risk behaviour	✓	!	✓	✓	✓	✓	✓
3.1.4.	Research undertaken, and evidence generated and synthesized to design key interventions in reproductive, maternal, newborn, child and adolescent health, and other conditions and issues linked to it	✓	✓	✓	!	✓	✓	✓

Budget and expenditure by Major office, 2014–2015 (US$ 000)

	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Health Assembly-approved budget	68 900	12 100	14 200	7000	14 600	12 100	103 900	232 800
Funds available (as at 31 December 2015)								
Flexible funds	20 053	6892	7075	3469	7729	3283	13 538	62 039
Voluntary contributions specified	56 682	1772	4070	3153	7774	6182	114 504	194 137
Total	**76 735**	**8664**	**11 145**	**6622**	**15 503**	**9465**	**128 042**	**256 176**
Funds available as a % of budget	111%	72%	78%	95%	106%	78%	123%	110%
Staff costs	24 905	4441	4179	3 036	4860	3502	49 332	94 255
Activity costs	44 417	4083	5806	3 320	8603	5346	59 944	131 519
Total expenditure	**69 322**	**8524**	**9985**	**6356**	**13 463**	**8848**	**109 276**	**225 774**
Expenditure as a % of approved budget	101%	70%	70%	91%	92%	73%	105%	97%
Expenditure as a % of funds available	90%	98%	90%	96%	87%	93%	85%	88%
Staff expenditure by major office	26%	5%	4%	3%	5%	4%	52%	100%

[1] Available at http://extranet.who.int/programmebudget/Biennium2016/Programme/Overview/165, accessed 7 April 2016.

3.2 AGEING AND HEALTH

OUTCOME 3.2. INCREASED PROPORTION OF OLDER PEOPLE WHO CAN MAINTAIN AN INDEPENDENT LIFE

Strategies to foster healthy ageing

Today, for the first time in history, most people can expect to live into their sixties and beyond. When combined with falling fertility rates, these increases in life expectancy are leading to the rapid ageing of populations around the world. And the pace of change is much faster than was the case in the past.

Longer life is an incredibly valuable resource. It provides the opportunity for reconsidering not just what older age might be, but how our whole lives might unfold. However, the extent of the opportunities that arise from these extra years of life will be very heavily dependent on one key factor: health. If people are experiencing them in good health, their ability to do the things they value will be little different to that of a younger person. If these added years are dominated by declines in physical and mental capacity, the implications for older people and for society are much more negative.

While it is often assumed that increasing longevity is being accompanied by an extended period of good health, the evidence that older people are experiencing better health today than their parents did at the same age is very limited. A coherent and focused public health response that spans multiple sectors and stakeholders is urgently needed. To date, this has largely been lacking. To address this clear gap, the Sixty-sixth World Health Assembly in 2013 identified ageing as a priority area of work for WHO.

Yet this was a field plagued by widespread misconceptions and fundamental knowledge gaps, and that lacked a clear strategic framework for public health action. Moreover, while the work of many WHO units at all levels of the Organization relates directly or indirectly to the health of older people, these activities have traditionally been undertaken in isolation from each other. For WHO to provide the leadership that was clearly needed in this area, a number of basic steps were required to provide the foundations for an effective and sustainable movement.

As an initial step, in early 2014, WHO established the WHO Ageing and Health Coordination Forum to foster a "whole of Organization" response to the topic. The Forum meets regularly, bringing together representatives of key departments and linking with focal points in each regional office. The Forum enabled the building of a shared vision of what needed to be achieved.

This shared vision was outlined in detail in the 2015 *World report on ageing and health*. The report drew on 19 background papers to summarize what is currently known about ageing. It also challenged many pervasive misconceptions and defined a new and evidence-based public health framework for action. Central to this framework is a reconceptualization of healthy ageing around the building and maintenance of functional ability across the life-course.

The report identifies four core strategies to foster healthy ageing: aligning health systems to the older populations they increasingly serve, developing long-term care systems, creating age-friendly environments, and better measurement, monitoring and research. The report has been well received and within two months of its release, over 20 000 copies had been downloaded.

To consolidate the engagement of Member States and to focus the contributions of all stakeholders, the Sixty-seventh World Health Assembly in 2014, called on WHO to develop a global strategy and action plan on ageing and health. Building on the framework outlined in the report, and drawing on an extensive consultation, which included over 600 web-based inputs and a face-to-face meeting involving over 70 Member States and 200 participants overall, a draft strategy was submitted for consideration by the Executive Board at its 138th session in January 2016.

To help fill knowledge gaps regarding the health and needs of older people in low- and middle-income countries, WHO, with the support of the United States National Institute of Aging, is undertaking a detailed longitudinal study of over 40 000 older people in China, India, Ghana, South Africa, Mexico and the Russian Federation. The first findings of this research became available during the biennium.

These strategic initiatives have been complemented by ongoing support provided to many Member States by regional and country offices to help identify and address the needs of older people for improved health care. Knowledge translation projects in China and Ghana looked to establish fresh approaches that could most effectively draw on all levels of the Organization to support countries in developing evidence-based policy. WHO has also continued to support municipalities directly through their engagement with the WHO Global Network of Age-friendly Cities and Communities, which now has over 300 members.

The biennium 2014–2015 has thus been a critical period for redefining the global agenda on ageing. The strong and broad support for the *World report on ageing and health* and the global strategy and action plan on ageing and health is an endorsement of WHO's global leadership role on the topic, and the foundation has now been laid to enable the Organization to build a sustained and targeted public health response. The strategic vision and framework for action is now in place, as is a mechanism for drawing on the total resources of the Organization in a coordinated way.

The normative work developed on ageing during 2014–2015 (the *World report on ageing and health* and the global strategy) is a direct contribution to the outcome indicator under this programme area which requires the development of global indicators as a framework for monitoring ageing. The work also illustrates how a small department in WHO can leverage the whole of the Organization towards a common cross-cutting issue.

The table below shows overall output achievements by major office. For more detailed information on the work implemented under this programme area, including explanations of output ratings, please consult the programme budget web portal.[1]

(✓)Fully delivered/contributed (!) Partly delivered/contributed (X) Not delivered/contributed (n/a) Not applicable

Output		Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
3.2.1.	Countries enabled to develop policies and strategies that foster healthy and active ageing, and improve access to, and coordination of, chronic, long-term and palliative care	!	✓	✓	✓	✓	✓	✓
3.2.2.	Technical guidance and innovations that identify and address the needs of older people for improved health care	!	✓	✓	✓	✓	✓	!
3.2.3.	Policy dialogue and technical guidance provided to countries focusing on the health of women beyond the reproductive age	X	!	✓	✓	n/a	✓	✓

[1] Available at http://extranet.who.int/programmebudget/Biennium2016/Programme/Overview/166, accessed 7 April 2016.

Budget and expenditure by major office, 2014–2015 (US$ 000)

	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Health Assembly-approved budget	700	1100	300	1500	1000	200	4700	9500
Funds available (as at 31 December 2015)								
Flexible funds	182	903	408	514	465	234	3502	6208
Voluntary contributions specified	143	0	67	558	0	367	783	1918
Total	**325**	**903**	**475**	**1 072**	**465**	**601**	**4285**	**8126**
Funds available as a % of budget	46%	82%	158%	71%	47%	301%	91%	86%
Staff costs	410	436	166	731	211	276	3043	5273
Activity costs	231	451	326	257	229	317	1135	2946
Total expenditure	**641**	**887**	**492**	**988**	**440**	**593**	**4178**	**8219**
Expenditure as a % of approved budget	92%	81%	164%	66%	44%	297%	89%	87%
Expenditure as a % of funds available	197%	98%	104%	92%	95%	99%	98%	101%
Staff expenditure by major office	8%	8%	3%	14%	4%	5%	58%	100%

3.3 GENDER, EQUITY AND HUMAN RIGHTS MAINSTREAMING

OUTCOME 3.3. GENDER, EQUITY AND HUMAN RIGHTS INTEGRATED INTO THE SECRETARIAT'S AND COUNTRIES' POLICIES AND PROGRAMMES

Moving from the abstract to country examples

The general objective of all WHO's work is to increase population health and reduce health inequities. Sustained improvement to physical, mental and social well-being requires action on human rights principles and on gender and the social determinants of health. Reducing health inequities within and between countries is embedded in WHO's Constitution and reflected as one of the six leadership priorities in the Twelfth General Programme of Work, 2014–2019. Finally, the Sustainable Development Goals integrate inequity reduction as a cross-cutting aim of all the goals and in Goal 10 equity is an end in its own right. The work under programme area 3.3 in 2014–2015 was twofold.

Within the Organization, work in 2014–2015 has been devoted to guiding and facilitating the mainstreaming of equity, human rights, gender and social determinants (ERGS). Mainstreaming ERGS in WHO means that all levels and offices prioritize and integrate ERGS within their programmes. A shift in institutional culture, management and work processes has incrementally been introduced. It also requires a renewed appraisal by the programme areas of how health and implementation challenges are viewed and analysed; how decisions are made; which policy and intervention recommendations are made; and how implementation is carried out and progress monitored.

To ensure a uniform approach across WHO, the different levels of the Organization came together and agreed on a set of seven essential mainstreaming criteria: data disaggregation; gender analysis; equity analysis; gender responsiveness; equity enhancement; implementation of AAAQ (availability, accessibility, acceptability and quality); and use of participatory approaches to remove barriers to inclusion. Seven short interactive e-learning

modules were developed for WHO staff to improve the skills needed to implement the seven criteria. New staff were introduced to the ERGS concepts during induction programmes and face-to-face learning sessions conducted in several regions. To ensure that WHO's mainstreaming criteria are embedded in global normative guidance, a chapter was included in the revised WHO handbook for guideline development, and in the handbook for induction of heads of WHO country offices. While a few programmes were already working along these lines, ERGS was not well integrated into the statutory planning and assessment processes of WHO. The development of the Programme budget 2016–2017 took steps to make ERGS more visible and the performance assessment process for 2014–2015 requires the programme areas to demonstrate concrete examples of effective mainstreaming.

In the biennium 2014–2015 there has been remarkable action in all six WHO regions and as a result 46 countries have made their national health policies, plans and laws more equitable, gender responsive and aligned with human rights. The avenue taken and the entry points vary according to the national context but the biennium saw ERGS moving from the abstract to practical, applicable country examples. For example, the Ministry of Health of Cambodia finalized a gender mainstreaming strategy and action plan. The Republic of Moldova began work to integrate gender, equity and human rights into its national child and adolescent strategy. Monitoring of health inequalities is a powerful engine for country action. Robust analysis of health data permits national stakeholders to understand the social contexts under which health programmes are being delivered and can bring a better understanding of what parameters must change to achieve better health for all – health that leaves no one behind. Thirty-five countries received technical support from WHO to strengthen the collection of disaggregated data. The Regional Office for Africa participated in the revision of the Gender Development Index, coordinated by the United Nations Economic Commission for Africa. To ensure wider dissemination and uptake, the WHO regional offices for the Eastern Mediterranean and the Americas translated the WHO handbook on health inequality monitoring into Arabic and Spanish.

The work in 2014–2015 on mainstreaming ERGS inside WHO has a direct link to the outcome indicator under Outcome 3.3 that relates to ensuring that processes are in place to ensure that gender, equity and human rights are measured in Secretariat programmes.

The table below shows overall output achievements by major office. For more detailed information on the work implemented under this programme area, including explanations of output ratings, please consult the programme budget web portal. There is also a summary of the experiences of mainstreaming of individual technical programmes as well as a progress report concerning progress towards reaching the United Nations System-wide Action Plan targets .[1]

(✓)Fully delivered/contributed (!) Partly delivered/contributed (X) Not delivered/contributed (n/a) Not applicable								
Output		Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
3.3.1.	Gender, equity and human rights are incorporated in routine strategic and operational planning and monitoring of Secretariat programmes	!	✓	✓	✓	✓	✓	✓
3.3.2.	Countries' capacity strengthened to integrate and monitor gender, equity and human rights in their health policies	✓	✓	✓	✓	✓	✓	✓

[1] Available at http://extranet.who.int/programmebudget/Biennium2016/Programme/Overview/167, accessed 7 April 2016.

Budget and expenditure by major office, 2014–2015 (US$ 000)

	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Health Assembly-approved budget	2300	2000	500	1300	1200	200	6400	13 900
Funds available (as at 31 December 2015)								
Flexible funds	221	1483	1362	826	525	204	2958	7579
Voluntary contributions specified	1368	117	142	119	568	927	1301	4542
Total	**1589**	**1600**	**1504**	**945**	**1093**	**1131**	**4259**	**12 121**
Funds available as a % of budget	69%	80%	301%	73%	91%	566%	67%	87%
Staff costs	260	1017	338	679	211	331	2696	5532
Activity costs	1249	678	770	252	818	782	1545	6094
Total expenditure	**1509**	**1695**	**1108**	**931**	**1029**	**1113**	**4241**	**11 626**
Expenditure as a % of approved budget	66%	85%	222%	72%	86%	557%	66%	84%
Expenditure as a % of funds available	95%	106%	74%	99%	94%	98%	100%	96%
Staff expenditure by major office	5%	18%	6%	12%	4%	6%	49%	100%

3.4 SOCIAL DETERMINANTS OF HEALTH

OUTCOME 3.4. INCREASED INTERSECTORAL POLICY COORDINATION TO ADDRESS THE SOCIAL DETERMINANTS OF HEALTH

Explaining the Health in All Policies approach

For every girl and boy, just crossing a street in many rapidly growing cities is a vital health issue. In such settings, parents and children alike face risks ranging from traffic injury due to poor street design and crosswalks, to exposure to heavy pollution from high-emission trucks and buses that burn polluting diesel fuel with poor pollution controls.

Such issues are at the core of a Health in All Policies approach – which aims to simultaneously advance health, equity and the attainment of Sustainable Development Goals at the national, regional and local levels.

Health in All Policies means taking account of the health impacts of decisions in other sectors, so that health risks may be minimized and synergies that improve health are amplified. A Health in All Policies approach is implicit to many of the new Sustainable Development Goals and targets. For example, two targets under Goal 11 (Sustainable cities and communities) aim to ensure that women, children, older persons and persons with disabilities have access to “safe, affordable, accessible and sustainable transport” (Target 11.2) and “safe, inclusive and accessible green and public spaces” (Target 11.7). Such targets recognize the synergies that such policies can have for reducing air pollution and traffic injuries and promoting healthy physical activity, with impacts, in particular, on the health of the most vulnerable groups.

Applying Health in All Policies approaches to health and sustainable development issues can support monitoring and tracking of the Sustainable Development Goals that encourages “a cross-cutting understanding of the significant interlinkages across the goals and targets”. Health in All Policies represents a key tool for the

health sector to identify social and environmental determinants of health and engage with other sectors in efforts to ensure “healthy lives and promote well-being for all at all ages” – in the language of Goal 3 (Good health and well-being).

Another cross-cutting theme of Health in All Policies is the reduction of inequalities among different population groups within countries and between countries. This is also key to Goal 10, on reducing inequalities within and among countries. Improving governance is also key to the Health in All Policies approach, while the Sustainable Development Goals stress the critical importance of intersectoral action and a whole-of-government approach as key to ensuring their achievement, and position health and health equity as key indicators to measure wider progress on sustainable development.

Recognizing these synergies, WHO has accelerated training in Health in All Policies approaches, through a series of global, regional and national training workshops. These included a global training-of-trainers workshop in Geneva in March 2015, followed by seven regional and subregional workshops or training courses in 2015 in Brazil, Finland, India, Mexico, New Zealand, South Africa and Suriname – events covering five of the six WHO regions. The workshops and courses made use of a new Health in All Policies training manual, developed by WHO. This manual is an adaptable resource to build capacity and promote engagement, collaboration and exchange on Health in All Policies.

The diversity of these events – in terms of the targeted participants, objectives and meeting structures – demonstrates both the considerable demand for concrete, practical tools and guidance on Health in All Policies as well as the adaptability of the manual and the versatility of its application to different contexts and themes.

These events have resonated in the policy arena. For instance, the Suriname workshop in May 2015 raised the political visibility of health inequities and social determinants of health in the country and laid the foundations for national strategic discussions on this theme, led by the Government of Suriname and supported by WHO. The key outcome was a comprehensive and intersectoral review of Health in All Policies for reducing health inequities in the country. For example, chronic kidney disease in Suriname was found to be more than 2.5 times more prevalent in the district of Saramacca, near the capital city of Paramaribo as compared to the more rural Coronie district. Nationally, Type 2 diabetes prevalence was almost three times higher among the poorest wealth quintiles compared to the richest; and smoking prevalence among the two poorest wealth quintiles was found to be three to four times higher than in the richest quintile.

Understanding of, and political commitment to, action on the social and environmental determinants of health and health equity has steadily increased. The Health in All Policies approach has received global recognition and endorsement, including through the 2010 Adelaide Statement on Health in All Policies, the outcome document of the 2012 Rio+20 Conference “The future we want”, and the 8th Global Conference on Health Promotion in 2013 – which centred on Health in All Policies – and the resulting Helsinki Statement, as well as the subsequent resolution WHA67.12, which called for the development of a framework for country action across sectors for health and health equity.

The need to involve many other sectors of society in addition to health in the struggle for a healthier society has also been a long-standing priority of WHO’s work in the environmental health arena. Actions by sectors such as energy, transport, housing and water are key to addressing the root environmental and social causes of ill-health that lie beyond the direct control of the health sector.

WHO’s biennium 2016–2017 includes plans for further national and regional workshops and adaptation of the Health in All Policies manual to focus on specific health risk factors, sectors and diseases such as air pollution, housing and noncommunicable diseases. It also includes efforts to build strategic alignment between the Health in All Policies manual and new tools and guidance being developed by WHO that contribute to the Sustainable Development Goals. These include the forthcoming WHO Innov8 approach to reviewing national health programmes, the WHO housing and health guidelines and the guidance on measuring and monitoring action on SDH.

The above is an illustration of the work that has been done under programme area 3.4 on the social determinants of health. The work of WHO on Health in All Policies contributes to increased capacity for intersectoral action and social participation in countries, which again contributes to the outcome targets in

closing equity gaps in access to, and provision of, health care services in respect of the poor and underprivileged communities.

The table below shows overall output achievements by major office. For more detailed information on the work implemented under this programme area, including explanations of output ratings, please consult the programme budget web portal.[1]

(✓)Fully delivered/contributed (!) Partly delivered/contributed (X) Not contributed (n/a) Not applicable								
Output		Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
3.4.1.	Increased country capacity to implement a health-in-all-policies approach, intersectoral action and social participation to address the social determinants of health	✓	✓	✓	✓	✓	✓	✓
3.4.2.	Effective guidance to countries to mainstream social determinants of health in all WHO programmes	✓	n/a	✓	✓	✓	✓	✓

Budget and expenditure by Major office, 2014–2015 (US$ 000)

	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Health Assembly-approved budget	7300	4200	1500	7600	1200	1400	7100	30 300
Funds available (as at 31 December 2015)								
Flexible funds	4364	3691	894	2934	921	403	3346	16 553
Voluntary contributions specified	181	47	30	3612	33	13	697	4613
Total	**4545**	**3738**	**924**	**6546**	**954**	**416**	**4043**	**21 166**
Funds available as a % of budget	62%	89%	62%	86%	80%	30%	57%	70%
Staff costs	3536	2793	479	3652	422	356	2571	13 809
Activity costs	865	1054	466	2347	522	60	815	6129
Total expenditure	**4401**	**3847**	**945**	**5999**	**944**	**416**	**3386**	**19 938**
Expenditure as a % of approved budget	60%	92%	63%	79%	79%	30%	48%	66%
Expenditure as a % of funds available	97%	103%	102%	92%	99%	100%	84%	94%
Staff expenditure by major office	26%	20%	3%	26%	3%	3%	19%	100%

[1] Available at http://extranet.who.int/programmebudget/Biennium2016/Programme/Overview/168, accessed 7 April 2016.

3.5 HEALTH AND THE ENVIRONMENT

OUTCOME 3.5. REDUCED ENVIRONMENTAL THREATS TO HEALTH

Health, air pollution and climate change – new knowledge

Until recently, the links between the soaring worldwide increase in noncommunicable diseases and the smog that we often see hanging over our cities was poorly understood.

Similarly, few people understood the multiple ways in which exposure to wood and coal cookstove smoke increases pneumonia rates among young children as well as the risks of developing chronic pulmonary disease among the women tending hearths and preparing meals for their families, day in and out in households in Africa, Latin America and South-East Asia.

Recent work by WHO to assess the burden of air pollution-related diseases, as well as to evaluate the linkages between health-harmful air pollutants and short- and long-lived climate pollutants, has reached a milestone. We now understand that air pollution is a major cause not only of acute and chronic respiratory illnesses, but also of significant mortality from stroke, heart disease and cancers. WHO has played a leading role in reaching this milestone in understanding – leading work on the burden of disease from air pollution, synthesis of evidence on effective interventions, and also developing guidelines on safe limits of emissions and ambient concentrations of the most harmful emissions, particularly fine particulate matter (PM2.5).

One of the most recent major milestones was the updated evidence of the global burden of disease from household and outdoor (ambient) air pollutants, issued by WHO in 2014. These estimates showed that air pollution was the cause of an estimated one in eight premature deaths worldwide, and the largest single environmental health risk today. Altogether, some 3.7 million deaths were attributed to outdoor air pollution in 2012, the latest year for which data were assessed, and some 4.3 million deaths to household air pollution sources, primarily smoky and inefficient coal and wood stoves.

In addition, an updated database of urban air pollution exposures, including data from some 1600 major cities worldwide, was published. These data showed that only 12% of the population covered by the available data lived in cities where air pollution levels met WHO guidelines for PM2.5. Many low- and middle-income cities, as well as some high-income cities, suffer from air pollution levels that are two to five times the guideline limits.

In November, 2014, new indoor air quality guidelines on household fuel combustion were released by WHO, providing for the first time ever health-based guidance on clean fuels and technologies for household cooking, heating and lighting. This extensive scientific assessment identifies what is clean energy in the home and the levels of emissions that pose health risks, as well as the critical role of avoiding kerosene, coal, wood and other solid fuel burning indoors for public health protection.

In May 2015, WHO Member States took a major step forward in addressing air pollution issues, through the adoption of the resolution WHA68.8 (Health and the environment: addressing the health impact of air pollution). More recently a draft road map for an enhanced global response to the adverse health effects of air pollution was reviewed by the WHO Executive Board, to be considered at the Sixty-ninth World Health Assembly in May 2016.

WHO has also stepped up both its technical work and its advocacy around air pollution and climate linkages, and led a scientific review of the links between short-lived climate pollutants, air pollutants and health, resulting in the report *Reducing global health risks through Mitigation of short-lived climate pollutants,* produced in cooperation with the Climate and Clean Air Coalition to Reduce Short-Lived Climate Pollutants (CCAC). This report looked at the health co-benefits of mitigating air pollution and climate pollutants through a single lens, highlighting the strong health sector interest in active cross-sectoral engagement with climate change mitigation. Fast growing city populations and multiple sources of air pollution in urban areas have led to worsening air quality in developing country cities. WHO is developing a new urban health initiative, to strengthen health sector capacity and pilot approaches to health sector action on air and climate pollutants in developing city settings, in collaboration with the Government of Norway, and many other United Nations, government, development and civil society partners in the CCAC.

Through close engagement with the Sustainable Energy for All Initiative, led by the United Nations Secretary-General, WHO is working to ensure that shifts to cleaner household and health sector energy sources are considered in the SE4ALL tracking mechanisms. Initiatives to support greater access to clean energy for health facilities and to develop clean household energy plans are being proposed and started in cooperation with SE4All partners. These would provide support to countries to respond to the widespread lack of clean energy access among health facilities in sub-Saharan Africa, describing how more reliable energy access could help reduce maternal mortality, improve newborn and child health, and support retention of health workers, as well as helping to implement the recommendations for clean household energy found in the WHO indoor air quality guidelines.

With regard to the post-2015 Agenda for Sustainable Development, WHO has contributed to ensure that heath-relevant indicators of household and ambient pollution exposure and disease burden can be part of the formal system of Sustainable Development Goal indicators. Monitoring of air pollution, its sources and health impacts is key for assessing the effectiveness of interventions and tracking progress. WHO has convened a global platform with United Nations agencies, government agencies, and research institutions to ensure access to and quality of information on human exposure to air pollutants, drawing on data from satellite remote sensing, emission inventories, and monitoring of pollutants. This has been successful in improving models and cross-validation of the data.

However, this is only the beginning. Major challenges still remain in obtaining more precise and more local data on air pollution exposure levels and health impacts. The health sector role in addressing air pollution also needs better definition and significant capacity building needs to take place. Few national ministries of health have air pollution specialists within their staff.

The air pollution example illustrates a number of WHO core functions, namely: shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge as well as setting norms and standards, and promoting and monitoring their implementation. This WHO work in the field of air pollution contributes to the outcome indicator related to the proportion of the population relying primarily on solid fuels for cooking.

The table below shows overall output achievements by major office. For more detailed information on the work implemented under this programme area, including explanations of output ratings, please consult the programme budget web portal.[1]

(✓)Fully contributed (!) Partly contributed (X) Not contributed (n/a) Not applicable

Output		Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
3.5.1.	Country capacity strengthened to assess health risks, develop and implement policies, strategies or regulations for the prevention, mitigation and management of the health impacts of environmental risks	✓	!	✓	✓	✓	✓	✓
3.5.2.	Norms, standards and guidelines to define environmental and occupational health risks and benefits associated with air quality, chemicals, water and sanitation, radiation, nanotechnologies, and climate change	✓	✓	✓	✓	✓	✓	✓
3.5.3.	Public health issues incorporated in multilateral agreements and conventions on the environment and sustainable development	!	✓	✓	✓	✓	✓	✓

[1] Available at http://extranet.who.int/programmebudget/Biennium2016/Programme/Overview/169, accessed 7 April 2016.

Budget and expenditure by major office, 2014–2015 (US$ 000)

	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Health Assembly-approved budget	12 800	12 800	7000	22 700	5100	7700	33 900	102 000
Funds available (as at 31 December 2015)								
Flexible funds	4399	2520	3041	4491	3028	2720	9471	29 670
Voluntary contributions specified	4672	289	4416	10 831	1146	6124	23 173	50 651
Total	**9071**	**2809**	**7457**	**15 322**	**4174**	**8844**	**32 644**	**80 321**
Funds available as a % of budget	71%	22%	107%	67%	82%	115%	96%	79%
Staff costs	3397	1554	2525	10 946	2500	3633	19 971	44 526
Activity costs	3788	1165	4619	3812	1673	4773	9771	29 601
Total expenditure	**7185**	**2719**	**7144**	**14 758**	**4173**	**8406**	**29 742**	**74 127**
Expenditure as a % of approved budget	56%	21%	102%	65%	82%	109%	88%	73%
Expenditure as a % of funds available	79%	97%	96%	96%	100%	95%	91%	92%
Staff expenditure by major office	8%	3%	6%	25%	6%	8%	45%	100%

Category 4

HEALTH SYSTEMS

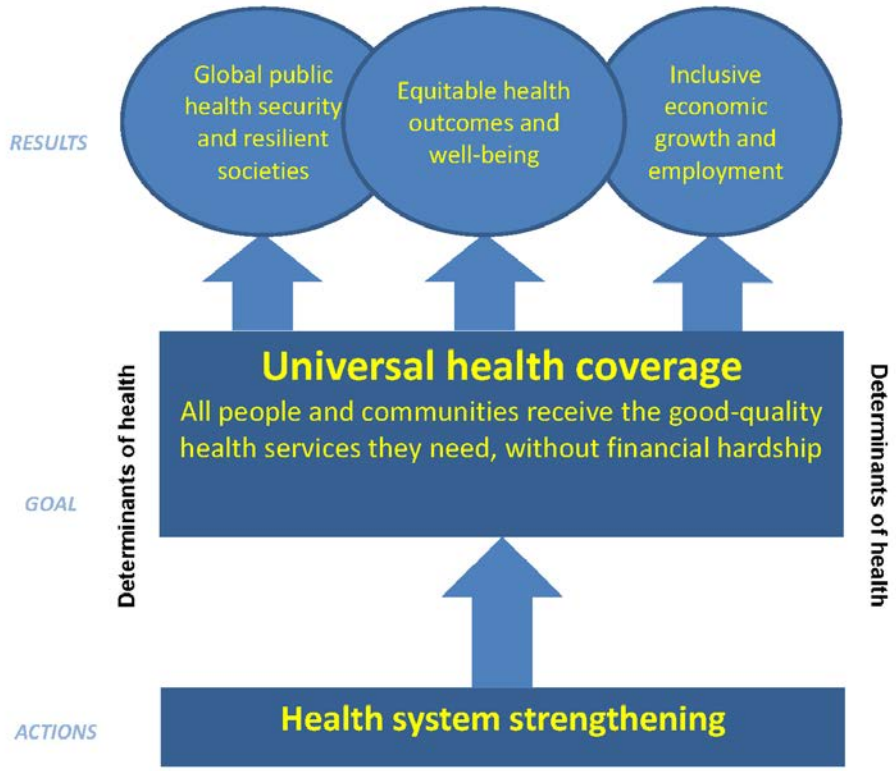
Category 4 brings together WHO's work on health systems strengthening, providing the underpinning for much of the Organization's work on universal health coverage.

It combines work on national health policies, strategies and planning, including health financing; integrated people-centred health services, which includes human resources for health; access to medicines and health technologies, including strengthening regulatory capacity; and health systems information and evidence.

The examples that follow illustrate the work carried out in each of the four component programme areas. While they cannot encompass the very wide range of WHO's health systems activities, they seek to show some of the more innovative aspects of the work carried out over the last two years.

Work on health systems strengthening is integral to the achievement of outcomes in relation to health across the life-course and to communicable and noncommunicable diseases as a component of universal health coverage. Strong health systems are also essential to ensuring both individual and global public health security. As sharply illustrated during recent health emergencies such as the Ebola and Zika virus disease outbreaks, or the natural disasters in Nepal and the Philippines, health system must also be prepared to guarantee the health security of the population and the resilience of societies. Health systems strengthening implies mobilizing financial resources or better prioritizing their allocation, as well as building the capacities of health systems in a variety of institutional, economic, fiscal, and political contexts. Importantly, health systems strengthening is a leading method – a series of approaches and tools, policies and actions – required to reach the goals of universal health coverage and the Sustainable Development Goals. Achieving these goals will, in turn, make essential contributions to global health security and resilient societies, equitable health outcomes and well-being, and inclusive economic growth – a dynamic further illustrated in the diagram below.

A framework for universal health coverage as part of the Sustainable Development Goals



CATEGORY 4 OVERALL FINANCIAL SUMMARY, 2014–2015 (US$ 000)

	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Health Assembly-approved budget	71 300	30 700	44 900	44 800	43 000	54 200	242 200	531 100
Funds available (as at 31 December 2015)								
Flexible funds	29 839	19 715	32 415	22 723	25 930	24 000	63 716	218 338
Voluntary contributions specified	49 266	3 111	12 466	19 413	16 858	21 132	178 592	301 586
Total	**79 105**	**22 826**	**44 881**	**42 136**	**42 788**	**45 132**	**242 308**	**519 924**
Funds available as a % of budget	111%	74%	100%	94%	100%	83%	100%	98%
Staff costs	34 398	16 608	17 461	18 074	18 679	19 880	142 831	267 931
Activity costs	36 782	6 604	25 458	21 538	20 011	22 926	66 867	200 186
Total expenditure	**71 180**	**23 212**	**42 919**	**39 612**	**38 690**	**42 806**	**209 698**	**468 117**
Expenditure as a % of approved budget	100%	76%	96%	88%	90%	79%	87%	88%
Expenditure as a % of funds available	90%	102%	96%	94%	90%	95%	87%	90%
Staff expenditure by major office	13%	6%	7%	7%	7%	7%	53%	100%

4.1 NATIONAL HEALTH POLICIES, STRATEGIES AND PLANS

OUTCOME 4.1. ALL COUNTRIES HAVE COMPREHENSIVE NATIONAL HEALTH POLICIES, STRATEGIES AND PLANS UPDATED WITHIN THE LAST FIVE YEARS

Participatory planning and evaluation processes in health policy-making

Evidence from both advanced and developing economies demonstrates that engaging individuals, families, communities, civil society organizations, parliamentarians and the media can have a positive impact on health literacy, patient experience, service utilization, health care costs and health outcomes. One of the most effective interventions is shared decision-making followed by multistakeholder reviews.

Dialogue societal in Tunisia: An example of WHO supporting population participation in health policy-making

In December 2010, Tunisia hit the headlines as a popular movement took hold in the country. Since then, policy has been driven by a commitment to ending high unemployment, corruption and poor living conditions, and to giving citizens a voice

Against this backdrop, and the changes in Tunisian society, it was imperative for a fundamental reorientation of the health sector to take place sooner rather than later. An in-depth population consultation was crucial to capture people's views, needs and daily challenges. A programme called "societal dialogue" ("dialogue sociétal") was launched in 2012, with technical support from WHO under the EU/Luxembourg–WHO Universal Health Coverage Partnership – with the emphasis being on the term "sociétal" in order to highlight the importance of having all of society's actors involved in the process of reform. It was clear at the time that the feasibility and acceptability of reforms in the political and social context that prevailed were highly dependent on people's participation. Thus the population consultation in Tunisia was carried out with the twin aims of capturing the population's opinion and of giving people a platform to express themselves in ways that they had never done before.

The first-ever "citizens' meetings on health" were organized in each governorate, where input was gathered on the key challenges in the health sector as well as the values and attitudes that should underpin reform. Simultaneously, focus groups were held for vulnerable populations in different parts of the country. The citizens' meetings and focus groups were then complemented by literature reviews and technical studies. Several major themes began to emerge as needing urgent reform. The next step was to select approximately 100 people by lottery from each of the governorates to form a "citizens jury" ("jury citoyen") for health. The jury was then given the task of deciding on specific questions around the following themes:

- solidarity and health system financing mechanisms;
- "neighbourhood health services" and coordination and integration of care;
- health promotion and health culture;
- confidence and revitalization of the health sector.

The feedback from these population consultation events has been overwhelmingly positive. Their huge popularity has led to the Government explicitly recommending this methodology to other sectors such as education and social services. In addition, it has helped citizens' groups to focus on key issues and strengthen their own capacity.

Population consultation in Tunisia: some numbers

- **96 lottery-selected jury members represented on the "citizens' jury" for health from 24 governorates**
- **120 hours of audio and video recorded material of citizens' voicing their concerns**
- **3424 citizens participating in the citizens' meetings on health**
- **20 556 kilometres travelled by facilitators for the various population consultation events**

Finally, the various population consultation events culminated in the "White Book" ("Livre Blanc"), the first-ever health sector diagnostic exercise conducted so comprehensively. It has served as a basis for the next five-year national health plan, which is currently being discussed and finalized.

Population consultation is one of the most effective ways to assess a population's needs and expectations, and to promote communities as active stakeholders in the planning process. Consultations need to include all key actors, including the media and parliamentarians as well as civil society organizations/nongovernmental organizations. A consultation, undertaken during the health planning cycle, can capture a population's demands and opinions on health-related matters, thereby improving national health planning and increasing the responsiveness of the health system to people's needs and expectations.

Consultations of the kind carried out in Tunisia thus provide information on people's needs while at the same time increasing a population's ownership of the resulting policies. Similarly, accountability and transparency are likely to be increased. Monitoring and evaluation mechanisms, usually included in a national health plan/strategy, can also be supported through consultations. In the long term, a regularly conducted and methodologically sound consultation can serve as an entry point for the establishment of institutionalized participatory processes (for example, joint annual health sector reviews).

Tunisia may be unique in some ways, but it is not the only example of WHO support to similar processes. In the Republic of Moldova, for example, under the EU/Luxembourg–WHO Universal Health Coverage Partnership, a first-ever national health forum was conducted in 2012, bringing together a wide range of stakeholders who had never convened together before. In Togo, WHO had a key role in helping the Ministry of Health lead a situation analysis, which was more in-depth, participatory and stakeholder-led than previous years. The situation analysis led to a national health plan for 2012–2015.

There are also many examples that show the importance of civil society organizations in this regard. "Coalition 15%", for example, a health platform of 18 civil society organizations created in 2009, which is active in Cameroon and Guinea Bissau and on its way to being set up in Benin, Congo and the Democratic Republic of the Congo, campaigned for the actual implementation of the 15% commitment of the Abuja Declaration (15% of public health expenditure allocated to health). Among many other activities, the platform maps governments' expenditures as well as donors' contributions, and advocates for increases to health budgets. The platform is also leading Universal Health Coverage Day mobilization, using the opportunity to inform citizens about access to health care and financial protection and to increase awareness about the right to health.

WHO is currently supporting over 70 countries on health policy dialogue, health financing and national health planning, of which 27 are more intensively supported under the EU/Luxembourg–WHO Universal Health Coverage Partnership. The objective is to expand the number of countries supported more intensively, given the huge demand and positive results.

The examples provided above are illustrations of the work that has been done under programme area on national health policies, strategies and plans. The table below shows overall output achievements by major office. For more detailed information on the work implemented under this programme area including explanations of output ratings, please consult the programme budget web portal.

(✓)Fully delivered/contributed (!) Partly delivered/contributed (X) Not delivered/contributed (n/a) Not applicable								
Output		Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
4.1.1.	Advocacy and policy dialogue to support countries to develop comprehensive national health policies, strategies and plans	✓	✓	✓	✓	✓	✓	✓
4.1.2.	Country capacity to develop and implement legislative, regulatory, and financial frameworks strengthened by generation and use of evidence, norms and standards, and robust monitoring and evaluation	✓	!	✓	✓	!	✓	✓

Budget and expenditure by major office, 2014–2015 (US$ 000)

	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Health Assembly-approved budget	15 200	14 500	12 600	17 600	11 100	15 400	39 300	125 700
Funds available (as at 31 December 2015)								
Flexible funds	7 094	4 833	9 739	5 528	4 960	8 786	6 910	47 850
Voluntary contributions specified	18 053	1 317	2 600	9 550	9 086	6 322	28 694	75 622
Total	**25 147**	**6 150**	**12 339**	**15 078**	**14 046**	**15 108**	**35 604**	**123 472**
Funds available as a % of budget	165%	42%	98%	86%	127%	98%	91%	98%
Staff costs	7 039	4 441	7 029	6 928	4 830	8 413	19 522	58 202
Activity costs	11 317	1 655	4 232	7 178	6 751	5 950	11 712	48 795
Total expenditure	**18 356**	**6 096**	**11 261**	**14 106**	**11 581**	**14 363**	**31 234**	**106 997**
Expenditure as a % of approved budget	121%	42%	89%	80%	104%	93%	79%	85%
Expenditure as a % of funds available	73%	99%	91%	94%	82%	95%	88%	87%
Staff expenditure by major office	12%	8%	12%	12%	8%	14%	34%	100%

4.2 INTEGRATED PEOPLE-CENTRED HEALTH SERVICES

OUTCOME 4.2. POLICIES, FINANCING AND HUMAN RESOURCES ARE IN PLACE TO INCREASE ACCESS TO INTEGRATED PEOPLE-CENTRED HEALTH SERVICES

Ensuring universal access to health workers

Health workers dominated media coverage of international health affairs in 2014–2015 *Time* magazine chose those fighting Ebola as "Person of the Year" in 2014, and tributes at the May 2015 Health Assembly poured in for the 513 health workers who died of Ebola. The 2015 Health Assembly also paid tribute to health workers who had been attacked in over 17 countries undergoing conflict and civil unrest since January 2014.

In Liberia, strengthening the health workforce is a top priority of the Ministry of Health's Investment Plan for Resilient Health Systems 2015–2021, with the creation of jobs and improvement of working conditions to boost recruitment and retention of the health workforce at its core. This stems from the recognition that the success of efforts to rebuild the health system hinges upon addressing fundamental issues that have an impact on the health workforce. That universal health coverage and global health security are contingent upon universal access to health workers is a premise that has formed the thrust of WHO's approach to the health workforce over the past 10 years. This has garnered attention and spurred the development of normative guidance and evidence on the core issues of health workforce shortages, recruitment and retention in rural and remote areas, health professionals' education, and international migration of health personnel. It has been effective in bringing together stakeholders in the health sector and achieving greater coherence, dialogue and collaboration through the Global Health Workforce Alliance as well as other forums.

The adoption of the Global Code of Practice on the International Recruitment of Health Personnel by the Sixty-third World Health Assembly in May 2010 was an important achievement – the first time in 30 years that WHO had used its constitutional authority to develop such a code. The 2015 review of the Code, submitted to the Sixty-eighth World Health Assembly, recognized its continuing relevance but urged all actors to strengthen institutional capacity for effective implementation so that its potential effectiveness could be fully realized. Unfortunately, the Code has not meaningfully changed the perspective that health workers are a cost to the public purse. Investing in health workers and investing in job strategies is good for the economy, yet in many countries health workforce investments have been cut and restrictions placed on hiring even in the face of substantial unmet health and social needs.

We have learnt the important lesson that more of the same will not suffice. Emerging evidence and the political momentum generated by the recently launched High-Level Commission on Health Employment and Economic Growth[1] positions the health workforce squarely as a matter of economic and international policy. The health workforce is not just an issue to be tackled by ministries of health; it is just as much a matter for Heads of State, and ministers of finance, education, foreign affairs and labour. Unemployment is an issue that is pertinent in all countries. Africa's youth bulge will mean that there will be more people of working age there by 2045 than in China or India; around 42 million people across the 34 countries of the OECD were unemployed in May 2015, 10 million more than before the financial crisis.[2] Youth unemployment rates across the European Union were at least double overall unemployment rates, with over 4.4 million young persons under the age of 25 years unemployed.[3] Yet most of the jobs created in OECD countries after the financial crisis have been in the services sector, with the growth in employment in the health and social sectors exceeding that of other sectors, contributing a large share of global economic growth (10.3% of world gross domestic product). Around half of

[1] For more information on the High-Level Commission, see http://www.who.int/hrh/com-heeg/en/ (accessed 6 April 2016).

[2] Scarpette S. Editorial: Time is running out to help workers move up the jobs ladder. In: OECD Economic Outlook 2015. Paris: OECD Publishing; 2015 (http://www.keepeek.com/Digital-Asset-Management/oecd/employment/oecd-employment-outlook-2015_empl_outlook-2015-en#page13, accessed 6 April 2016).

[3] Unemployment statistics. In: Eurostat statistics explained [website]. Luxembourg, European Commission (Eurostat); 2016 http://ec.europa.eu/eurostat/statistics-explained/index.php/Unemployment_statistics, accessed 6 April 2016).

the new private sector jobs in the United States between 2001 and 2012 were in the health sector. The health and social sector in the European Union employs 20 million people (10% of total employment). The health workforce is predominately female and increasingly feminized in many countries. Growth in health employment thus creates expanded decent work opportunities for women. The links between reduced unemployment, improved social cohesion and stability are obvious – can we look to the health and social sector employment for a triple return of decent work, global health security and better health?

The global economy is projected by the World Bank to create demand for an additional 40 million jobs in the health sector, mostly in middle- and high-income countries. This takes place against deepening mismatches and shortages primarily in low- and lower-middle-income countries that hinder efforts to achieve universal health coverage. Could guiding and investing in health employment accelerate the achievement of the Sustainable Development Goals by improving health, global health security, building skilled human capital, creating decent quality jobs and reducing poverty?

In establishing the Commission, the United Nations has set the stage for discussions and proposed actions that go beyond the boundaries of a traditional health agenda, an agenda around which the ILO, OECD and WHO have coalesced to support. The new agenda for the health workforce mirrors the interconnected ambitions embodied in the Sustainable Development Goals. WHO's work in 2016–2017 – reflected in the new Global Strategy for Human Resources for Health tabled at the Sixty-ninth World Health Assembly – recognizes the linkages between the health workforce and the broader agenda on inclusive economic growth, addressing unemployment, expanding sustainable opportunities for decent work, human rights and social protection and building a skilled labour force. WHO's new agenda on health employment, jobs and decent work seeks to be a catalyst in achieving the paradigm shift required to develop and implement solutions to address growing health workforce inequities and shape markets to harness opportunities in health employment to achieve the Sustainable Development Goals.

The above is an illustration of the work that has been done under programme area on integrated people-centred health services. The table below shows overall output achievements by major office. For more detailed information on the work implemented under this programme area including explanations of output ratings, please consult the programme budget web portal.

(✓)Fully delivered/contributed (!) Partly delivered/contributed (X) Not delivered/contributed (n/a) Not applicable								
Output		**Africa**	**Americas**	**South-East Asia**	**Europe**	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**
4.2.1.	Policy options, tools and technical support to countries for equitable people-centred integrated service delivery and strengthening of public health approaches	X	n/a	✓	✓	!	✓	!
4.2.2.	Countries enabled to plan and implement strategies that are in line with WHO's global strategy on human resources for health and the WHO Global Code of Practice on the International Recruitment of Health Personnel	✓	!	✓	✓	!	✓	✓
4.2.3.	Guidelines, tools and technical support to countries for improved patient safety and quality of services, and for patient empowerment	!	✓	✓	!	✓	✓	✓

Budget and expenditure by major office, 2014–2015 (US$ 000)

	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Health Assembly-approved budget	30 000	6 000	22 300	11 700	15 400	23 900	42 200	151 500
Funds available (as at 31 December 2015)								
Flexible funds	13 193	7 066	11 710	6 655	9 376	8 401	12 571	68 972
Voluntary contributions specified	12 058	561	7 187	7 205	3 244	5 411	16 049	51 715
Total	**25 251**	**7 627**	**18 897**	**13 860**	**12 620**	**13 812**	**28 620**	**120 687**
Funds available as a % of budget	84%	127%	85%	118%	82%	58%	68%	80%
Staff costs	15 245	5 800	5 417	4 252	5 390	5 219	19 606	60 929
Activity costs	11 100	2 058	13 705	8 408	6 784	7 955	8 429	58 439
Total expenditure	**26 345**	**7 858**	**19 122**	**12 660**	**12 174**	**13 174**	**28 035**	**119 368**
Expenditure as a % of approved budget	88%	131%	86%	108%	79%	55%	66%	79%
Expenditure as a % of funds available	104%	103%	101%	91%	96%	95%	98%	99%
Staff expenditure by major office	25%	10%	9%	7%	9%	9%	32%	100%

4.3 ACCESS TO MEDICINES AND HEALTH TECHNOLOGIES AND STRENGTHENING REGULATORY CAPACITY

OUTCOME 4.3. IMPROVED ACCESS TO AND RATIONAL USE OF SAFE, EFFICACIOUS AND QUALITY MEDICINES AND HEALTH TECHNOLOGIES

Reinforcing the principle of essential medicines through fair pricing

For the last 15 years, civil society has advocated for greater access to medicines in the developing world by invoking WHO's essential medicines concept – a package of medicines that must be quality-assured, affordable and available in a health system at all times to address the specific health challenges of a given population. Traditionally, access to essential medicines has been largely viewed as a “rich versus poor” story, with slogans decrying the fact that medicines were developed and priced for rich markets, and that pharmaceutical research and development largely favoured illnesses mostly present in wealthy regions.

Today we are in a new quandary. Prices for the latest generation of hepatitis C drugs, some of which cost US$ 1000 per pill, have ignited heated debates both developing and developed countries because providing them to all who need them is economically unsustainable. The costs of new cancer drugs have forced some national health services, for example in the United Kingdom, to exclude certain drugs from the list reimbursed by the Government, or to ration treatment. The question of which groups come first has raised difficult ethical debates and mobilized parliamentarians, access advocates and the media.

Just as occurred with the inclusion of patent-protected antiretroviral drugs in the WHO Model List of Essential Medicines 15 years ago, WHO in May 2015 included all new medicines for hepatitis C in its Model List of Essential Medicines, together with six new high-priced cancer treatments.

On the occasion of this ground-breaking decision, WHO's Director-General stated: "When new effective medicines emerge to safely treat serious and widespread diseases, it is vital to ensure that everyone who needs them can obtain them. Placing them on the WHO Essential Medicines List is a first step in that direction".[1] The message was clear – innovation and public health gains should be accessible to all and the onus was now on governments, insurance schemes and manufacturers to make the medicines accessible.

The manufacturers of these medicines argue that the high-risk cost of research and development, and especially the health value of the products, justify their prices. However, there are few data to support the costs cited for research and development, and much initial research for medicines is carried out in publicly funded institutions.

An affordable price is one of many determinants of access. But what is becoming increasingly apparent is that the current status of medicines prices is today one of the biggest challenges to health systems everywhere, regardless of income.

At the other end of the spectrum is the problem of drug shortages and stock-outs for older and off-patent medicines. Generic manufacturers are less interested in ensuring quality production of medicines that have very low prices. There are a number of examples – ranging from benzathine penicillin to older AIDS medicines and snake anti-venom – for which manufacturers are leaving the market or where quality has suffered severely.

The emergence of these concurrent issues is expanding the debate on medicine prices beyond the trade arena into one that requires public health intervention. It also places the principle of fairness centre stage. What is a fair profit for a research and development-based company, and what is a fair price for health systems to pay to progress to universal health coverage?

In tandem with a renewed effort to promote the Essential Medicines List as a powerful policy tool, WHO is embarking on a "fair pricing" initiative to help countries develop effective policies towards universal health coverage. A series of landscape analyses are planned throughout 2016, culminating in a forum with all key interest groups involved in the development, purchase and consumption of medicines. The underlying approach is to identify the most promising options and strategies to reduce the cost of new medicines, while ensuring that sufficient incentives remain for research and innovation, and that generic medicines also stay on the market.

WHO has both the mandate and the responsibility to address the challenge posed to public health by the prices of medicines. It provides a unique global policy platform to do so, through its convening power with all public health actors, national and international.

The overarching health objective of the 2030 Agenda for Sustainable Development is to promote good health for all and to ensure, through universal coverage, that people everywhere are able to afford the health services they need. *The Lancet* has recently stressed that essential medicines are crucial if countries are to achieve universal health coverage, and access will be a major goal for the post-2015 development agenda.[2] It is timely to urge greater involvement of global health in the policy dialogue on the pricing of medicines and to seek realistic solutions for improved access to medicines through greater affordability.

The above is an illustration of the work that has been done under programme area on access to medicines and health technologies and strengthening regulatory capacity. The table below shows overall output achievements by major office. For more detailed information on the work implemented under this programme area including explanations of output ratings, please consult the programme budget web portal.

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[1] WHO moves to improve access to lifesaving medicines for hepatitis C, drug-resistant TB and cancers [news release]. Geneva: World Health Organization; 8 May 2015 (http://www.who.int/mediacentre/news/releases/2015/new-essential-medicines-list/en/, accessed 4 April 2016).

[2] A new *Lancet* Commission on Essential Medicines. Lancet. 2014;384(9955):1642. doi: http://dx.doi.org/10.1016/S0140-6736(14)62017-1.

(✓)Fully delivered/contributed (!) Partly delivered/contributed (X) Not delivered/contributed (n/a) Not applicable								
Output		Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
4.3.1.	Countries enabled to develop or update, implement, monitor and evaluate national policies on better access to health technologies; and to strengthen evidence-based selection and rational use of health technologies	✓	✓	✓	✓	✓	✓	!
4.3.2.	Implementation of the global strategy and plan of action on public health, innovation and intellectual property	!	✓	✓	✓	n/a	✓	!
4.3.3.	Strengthening national regulatory authorities facilitated; norms, standards, guidelines for medical products developed; and quality, safety and efficacy of health technologies ensured through prequalification	✓	✓	✓	✓	✓	✓	✓

Budget and expenditure by major office, 2014–2015 (US$ 000)

	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Health Assembly-approved budget	11 600	5 700	4 700	7 000	7 300	8 900	100 300	145 500
Funds available (as at 31 December 2015)								
Flexible funds	3 817	2 834	5 933	1 944	4 651	3 419	13 227	35 825
Voluntary contributions specified	9 298	611	1 394	1 763	2 437	4 096	98 854	119 201
Total	**13 115**	**3 445**	**7 327**	**3 707**	**7 088**	**7 515**	**112 081**	**155 026**
Funds available as a % of budget	113%	60%	156%	53%	97%	84%	112%	107%
Staff costs	5 522	2 520	2 608	1 817	3 655	3 432	66 184	85 738
Activity costs	6 466	1 023	4 167	1 850	2 681	3 843	36 163	56 193
Total expenditure	**11 988**	**3 543**	**6 775**	**3 667**	**6 336**	**7 275**	**102 347**	**141 931**
Expenditure as a % of approved budget	103%	62%	144%	52%	87%	82%	102%	98%
Expenditure as a % of funds available	91%	103%	92%	99%	89%	97%	91%	92%
Staff expenditure by major office	6%	3%	3%	2%	4%	4%	77%	100%

4.4 HEALTH SYSTEMS, INFORMATION AND EVIDENCE

OUTCOME 4.4. ALL COUNTRIES HAVE PROPERLY FUNCTIONING CIVIL REGISTRATION AND VITAL STATISTICS SYSTEMS

Rationalizing health monitoring: A Global Reference List of 100 Health Indicators

Until recently some countries have had to report on more than 800 health indicators. This situation has arisen due to uncoordinated global investments in disease- and programme-specific monitoring and evaluation programmes by many different agencies. This in turn contributes to the existence of large numbers of indicators, diverse indicator definitions, different reporting frequencies, fragmented data collection and uncoordinated efforts to strengthen national institutional capacity. The net result: an unnecessary burden on countries and inefficiencies in strengthening country health information systems.

At an informal meeting in New York, United States of America, in September 2013, global health agency leaders decided to establish a group of senior focal points from each agency to review their respective agency's critical requirements for reporting from countries, with the aim of reducing the reporting burden. The Director-General of WHO then chaired an Interagency Working Group on Indicators and Reporting Burden, which carried out a rapid assessment of the burden of indicators and reporting requirements. The subsequent report[1] analysed the situation from both the global and country perspectives.

One of the priority actions identified by the interagency working group was that global agencies should bring greater alignment and efficiency to their investments by rationalizing existing reporting demands, thereby reducing reporting requirements and easing the reporting burden on countries. To achieve this, WHO worked with international and multilateral partners and countries to develop and agree on a global reference list of 100 health indicators. The key idea is that these indicators will be given priority by all agencies for monitoring national and global progress, for assessing the need for programme support, and for advocating for resources and funding. The list was developed from existing lists that had been recommended in the context of international governing bodies of international organizations and forums, global and regional health initiatives, technical reference groups and programmes.

The intensive collaboration of 20 global health agencies led to the Global Reference List of 100 Health Indicators for results monitoring. This list is a standard set of 100 indicators prioritized by the global community to provide concise information on the health situation and trends, including responses at national and global levels. The Global Reference List contains indicators of relevance to country, regional and global reporting across the spectrum of global health priorities relating to the health-related targets of the Sustainable Development Goals. These include the Millennium Development Goals agenda, as well as new and emerging priorities such as noncommunicable diseases, universal health coverage and other issues in the post-2015 development agenda.

The aim of the Global Reference List is to contribute to the reduction of reporting requirements and to promote greater alignment with, and investment in, a country-led health sector platform for results and accountability that forms the basis for global reporting.[2] The Global Reference List aims at rationalization and encourages stakeholders to consider only the most important and critical indicators.

The Global Reference List is a means to an end. The main objectives are:

- to guide monitoring of health results nationally and globally;
- to reduce excessive and duplicative reporting requirements;
- to enhance efficiency of data collection investments in countries;

[1] A rapid assessment of the burden of indicators and reporting requirements for health monitoring. Report prepared for the Interagency Working Group on Indicators and Reporting Burden by the WHO Department of Health Statistics and Information Systems. Geneva: World Health Organization; 2014.

[2] Monitoring, evaluation and review of national health strategies. A country-led platform for information and accountability. Geneva: World Health Organization; 2011.

- to enhance availability and quality of data on results; and
- to improve transparency and accountability.

An outcome statement was prepared and agreed upon at the meeting of global health agency leaders on 24 September 2015, which puts the Global Reference List in a broader context. Since then, the list has already been used in developing monitoring frameworks for global strategies and action plans in several countries.

The updating of the Global Reference List will be undertaken by the Health Data Collaborative, which is a multipartner initiative to be launched in May 2016 with a small secretariat at WHO and designated staff at several other United Nations and bilateral agencies and civil society coalitions. The Health Data Collaborative aims to enhance the efficiency and effectiveness of health data investments in order to strengthen country-led health information systems in the context of the Sustainable Development Goals.

The above is an illustration of the work that has been done under programme area on health systems, information and evidence. The table below shows overall output achievements by major office. For more detailed information on the work implemented under this programme area including explanations of output ratings, please consult the programme budget web portal.

(✓)Fully delivered/contributed (!) Partly delivered/contributed (X) Not delivered/contributed (n/a) Not applicable								
Output		**Africa**	**Americas**	**South-East Asia**	**Europe**	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**
4.4.1.	Comprehensive monitoring of the global, regional and country health situation, trends and determinants, using global standards, and leadership in the new data generation and analyses of health priorities	✓	✓	✓	✓	✓	✓	!
4.4.2.	Countries enabled to plan, develop and implement an eHealth strategy	✓	!	✓	✓	✓	✓	✓
4.4.3.	Knowledge management policies, tools, networks, assets and resources developed and fully utilized by WHO and countries to strengthen their capacity to generate, share and apply knowledge	✓	✓	✓	✓	✓	✓	✓
4.4.4.	Policy options, tools and support provided to define and promote research priorities, and to address priority ethical issues related to public health and to research for health	✓	✓	✓	✓	✓	!	!

Budget and expenditure by major office, 2014–2015 (US$ 000)

	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Health Assembly-approved budget	14 500	4 500	5 300	8 500	9 200	6 000	60 400	108 400
Funds available (as at 31 December 2015)								
Flexible funds	5 735	4 982	5 033	8 596	6 943	3 394	31 008	65 691
Voluntary contributions specified	9 857	622	1 285	895	2 091	5 303	34 995	55 048
Total	**15 592**	**5 604**	**6 318**	**9 491**	**9 034**	**8 697**	**66 003**	**120 739**
Funds available as a % of budget	108%	125%	119%	112%	98%	145%	109%	111%
Staff costs	6 592	3 847	2 407	5 077	4 804	2 816	37 519	63 062
Activity costs	7 899	1 868	3 354	4 102	3 795	5 178	10 563	36 759
Total expenditure	**14 491**	**5 715**	**5 761**	**9 179**	**8 599**	**7 994**	**48 082**	**99 821**
Expenditure as a % of approved budget	100%	127%	109%	108%	93%	133%	80%	92%
Expenditure as a % of funds available	93%	102%	91%	97%	95%	92%	73%	83%
Staff expenditure by major office	10%	6%	4%	8%	8%	4%	59%	100%

Category 5

PREPAREDNESS, SURVEILLANCE AND RESPONSE

This category focuses on strengthening countries' capacities in prevention, preparedness, response and recovery for all types of hazards, risks and emergencies that pose a threat to human health.

In 2014–2015 there was an unprecedented number of health crises, which required WHO to respond to multiple simultaneous disease outbreaks and other emergencies. The outbreak of Ebola was the largest and most complex Ebola outbreak since the virus was discovered.

The Ebola outbreak, together with other disease outbreaks and natural disasters, such as typhoon Haiyan, showed clearly that approaches to emergency management are not effective if fragmented and narrowly focused. A coordinated multi-hazard approach that covers essential elements such as enhanced prevention, emergency risk reduction, preparedness, surveillance, response and early recovery is a more optimal way to address this issue.

The Sendai Framework for Disaster Risk Reduction 2015–2030 aims to substantially reduce risk and loss through integrated and multisectoral actions. WHO championed the integration of health into the Sendai Framework. The Sendai Framework puts health at the centre of global policy and action to reduce disaster risks, takes an all-hazards approach and includes epidemics and pandemics within its scope. In line with this, WHO has worked with Member States and other stakeholders on the development of an Emergency Disaster Risk Management for Health policy framework, which is intended to serve as an overarching policy across all types of hazards.

WHO needs to be able to provide multisectoral leadership in large-scale public health emergencies and have the internal systems and structures in place to support these efforts in an effective and efficient manner.

WHO's significant emergency reform will take into consideration the lessons learnt in the biennium 2014–2015 as well as the recommendations from the United Nations Secretary-General's High-level Panel on the Global Response to Health Crises.[1]

CATEGORY 5 OVERALL FINANCIAL SUMMARY

BASE

Budget and expenditure by major office, 2014–2015 (US$ 000)

	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Health Assembly-approved budget	55 500	16 200	16 600	13 700	17 200	29 400	138 400	287 000
Funds available (as at 31 December 2015)								
Flexible funds	23 284	7 420	7 690	5 417	11 641	7 110	49 354	111 916
Voluntary contributions specified	28 415	3 928	11 187	9 147	23 112	18 867	72 732	167 399
Total	**51 699**	**11 348**	**18 877**	**14 564**	**34 753**	**25 977**	**122 086**	**279 315**
Funds available as a % of budget	93%	70%	114%	106%	202%	88%	88%	97%
Staff costs	22 647	5 569	8 908	7 509	17 651	10 978	86 929	160 191
Activity costs	25 874	5 385	8 709	6 547	16 576	14 166	28 279	105 536
Total expenditure	**48 521**	**10 954**	**17 617**	**14 056**	**34 227**	**25 144**	**115 208**	**265 727**
Expenditure as a % of approved budget	87%	68%	106%	103%	199%	86%	83%	93%
Expenditure as a % of funds available	94%	97%	93%	97%	98%	97%	94%	95%
Staff expenditure by major office	14%	3%	6%	5%	11%	7%	54%	100%

[1] See United Nations General Assembly document A/70/723 (available at http://www.un.org/ga/search/view_doc.asp?symbol=A/70/723 accessed 14 April 2016).

EMERGENCIES

Budget and expenditure by major office, 2014–2015 (US$ 000)

	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Health Assembly-approved budget	447 500	11 100	74 800	9 000	291 300	6 900	87 300	927 900
Funds available (as at 31 December 2015)								
Flexible funds	9 157	16	2 480	31	3 830	170	21 434	37 118
Voluntary contributions specified	926 883	8 120	92 619	20 877	524 029	27 867	273 195	1 906 413
Total	**936 040**	**8 136**	**95 099**	**20 908**	**527 859**	**28 037**	**294 629**	**1 943 531**
Funds available as a % of budget	209%	73%	127%	232%	181%	406%	337%	209%
Staff costs	140 196	782	5 048	3 764	43 193	2 824	59 305	255 112
Activity costs	699 669	6 753	77 667	13 521	429 833	23 955	189 653	1 441 051
Total expenditure	**839 865**	**7 535**	**82 715**	**17 285**	**473 026**	**26 779**	**248 958**	**1 696 163**
Expenditure as a % of funds available	90%	93%	87%	83%	90%	96%	84%	87%
Staff expenditure by major office	55%	0%	2%	1%	17%	1%	23%	100%

5.1 ALERT AND RESPONSE CAPACITIES

OUTCOME 5.1. ALL COUNTRIES HAVE THE MINIMUM CORE CAPACITIES REQUIRED BY THE INTERNATIONAL HEALTH REGULATIONS (2005) FOR ALL-HAZARD ALERT AND RESPONSE

Building competence to achieve health security

Building on the achievements of the International Health Regulations (2005) implementation course (2010–2012), developed to facilitate understanding and application of the Regulations by WHO staff and national focal points, WHO set up a comprehensive approach to learning and human resources development on health security under the International Health Regulations (2005) framework geared at both individual and institutional levels. This approach seeks to increase the number of professionals sharing a common approach to interpreting and applying the framework; to support countries to institutionalize training on the International Health Regulations (2005); and to facilitate adaptation of the programmes and activities according to their respective national contexts.

The Health Security Learning Platform, a virtual learning environment, has been set up to assist Member States in preparing upcoming generations of public health leaders and professionals. It enables Member States to design and plan learning activities on health security issues, using and adapting approaches and materials offered through the platform, based on national contexts and needs. Several learning and training materials are made publicly available, including a national rapid response team training package that has been critical for outbreak preparedness.

In September 2014, to support the response to the Ebola outbreak and working with the relevant technical teams, the WHO training team further broadened its scope and developed Ebola-specific, face-to-face and

online trainings packages, ranging from pre-deployment occupational safety, to infection prevention and control, to Ebola case management at ports and airports.

In 2015, to further support preparedness in Member States for Ebola and other major outbreaks, the WHO human resources development and training team developed the national rapid response teams training package, a comprehensive collection of modular training resources and tools enabling relevant training institutions in the WHO regions and Member States to organize, run and evaluate an eight-day training course for national rapid response teams, tailored to specific countries' needs.

The training of rapid response teams aims at reinforcing the capacity and skills of these multidisciplinary teams and their individual members to strengthen early detection and control of, and response to, public health events within a coordinated incident management system. Besides technical expertise, the training course contributes to the national coordination of emergency responses, and aims at strengthening teambuilding. A forum for continuous learning upon completion of the training course is also provided.

This work will continue in 2016 with training-of-trainers courses and, together with partners, possible development of the development of a competency framework for rapid response teams.

The above is an illustration of the work that has been done under programme area on alert and response capacities. It illustrates the contribution of the Secretariat to one of the six leadership priorities of the Twelfth General Programme of Work, namely helping to ensure that all countries can meet the capacity requirements specified in the International Health Regulations (2005).

The table below shows overall output achievements by major office. For more detailed information on the work implemented under this programme area including explanations of output ratings, please consult the programme budget web portal.

(✓)Fully delivered/contributed (!) Partly delivered/contributed (X) Not delivered/contributed (n/a) Not applicable								
Output		**Africa**	**Americas**	**South-East Asia**	**Europe**	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**
5.1.1.	Countries enabled to develop core capacities required under International Health Regulations (2005)	✓	✓	!	!	!	✓	!
5.1.2.	WHO has the capacity to provide evidence-based and timely policy guidance, risk assessment, information management and communications for all acute public health emergencies	✓	!	✓	✓	!	✓	!

Budget and expenditure by major office, 2014–2015 (US$ 000)

	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Health Assembly-approved budget	8 400	6 300	6 000	7 500	5 000	15 100	49 700	98 000
Funds available (as at 31 December 2015)								
Flexible funds	5 248	2 051	3 371	1 575	2 800	2 828	18 716	36 589
Voluntary contributions specified	4 587	0	4 427	3 788	5 747	9 775	21 492	49 816
Total	**9 835**	**2 051**	**7 798**	**5 363**	**8 547**	**12 603**	**40 208**	**86 405**
Funds available as a % of budget	117%	33%	130%	72%	171%	83%	81%	88%
Staff costs	3 156	1 612	4 059	2 677	2 224	5 395	29 214	48 337
Activity costs	5 884	469	2 865	2 496	5v223	7 128	7 793	31 858
Total expenditure	**9 040**	**2 081**	**6 924**	**5 173**	**7 447**	**12 523**	**37 007**	**80 195**
Expenditure as a % of approved budget	108%	33%	115%	69%	149%	83%	74%	82%
Expenditure as a % of funds available	92%	101%	89%	96%	87%	99%	92%	93%
Staff expenditure by major office	7%	3%	8%	6%	5%	11%	60%	100%

5.2 EPIDEMIC-PRONE AND PANDEMIC-PRONE DISEASES

OUTCOME 5.2. INCREASED CAPACITY OF COUNTRIES TO BUILD RESILIENCE AND ADEQUATE PREPAREDNESS TO MOUNT A RAPID, PREDICTABLE AND EFFECTIVE RESPONSE TO MAJOR EPIDEMICS AND PANDEMICS

Cholera prevention and control

Cholera is a major public health issue in many countries struggling with poverty, rapid population growth and instability. Outbreaks are devastating and affect vulnerable populationswith no or limited access to safe water and sanitation.

Although preventable and treatable, cholera still results in an estimated 1.4 to 4.3 million cases and 28 000 to 142 000 deaths per year worldwide. Cases remain underreported. In 2014, 190 549 cholera cases and 2231 deaths were reported by 42 countries, with 55% of all cases reported from Africa, 30% from Asia and 15% from the Dominican Republic and Haiti.

In line with the Programme budget 2014–2015, programme area 5.2 on epidemic- and pandemic-prone diseases put in place comprehensive and multidisciplinary approaches and established global mechanisms to address the international dimension of cholera, across the three levels of the Organization, working towards achieving its six-year outcome “Increased capacity of countries to build resilience and adequate preparedness to mount a rapid, predictable and effective response to major epidemics and pandemics” and category 5 impact “Prevention of death, illness and disability arising from emergencies”.

To tackle this continuing issue, WHO has adopted two major strategies, engaging and mobilizing international communities to leverage funds and support, and introducing new tools for prevention and control, without abandoning the comprehensive multisectoral interventions and control strategies.

The Global Task Force on Cholera Control was successfully revitalized in 2014, comprising more than 30 partners including United Nations agencies, nongovernmental organizations, and academic and research institutions. Effective coordination of the network has been realized, and global partnership strengthened with a second meeting in 2015, and the creation of six working groups to integrate all cholera preventive and control activities, such as epidemiological and laboratory surveillance, patient care, vaccination, training, social mobilization, advocacy, and water, sanitation and hygiene.

Life-saving interventions have been implemented thanks to the establishment and management of the oral cholera vaccine stockpile, including country support and operations. Vaccine campaigns and well-targeted preventive interventions have been implemented to alleviate the burden of cholera on populations living in high-risk areas and during humanitarian crisis and cholera outbreaks. Since inception of the oral cholera vaccine stockpile in July 2013, the stockpile has been successfully deployed for 21 mass campaigns, reaching nearly 3.5 million of people in 2014–2015 alone, in 11 countries (Cameroon, Ethiopia, Guinea, Haiti, Iraq, Malawi, Mozambique, Nepal, Sudan, South Sudan and the United Republic of Tanzania).

Programme area 5.2 on epidemic-prone and pandemic-prone diseases ensures continued determination and innovation in the domain of cholera prevention, epidemiology, vaccinology and diagnostics, as well as increased access to vaccines and rejuvenated coordination of control efforts through the Global Task Force on Cholera Control, all being success elements for progress in both endemic and epidemic situations.

The above is an illustration of the work that has been done under programme area on epidemic-prone and pandemic-prone diseases. The table below shows overall output achievements by major office. For more detailed information on the work implemented under this programme area including explanations of output ratings, please consult the programme budget web portal.

(✓)Fully delivered/contributed (!) Partly delivered/contributed (X) Not delivered/contributed (n/a) Not applicable

Output		Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
5.2.1.	Countries are enabled to develop and implement operational plans, in line with WHO recommendations on strengthening national resilience and preparedness covering pandemic influenza and epidemic and emerging diseases	✓	!	✓	✓	✓	✓	✓
5.2.2.	Expert guidance and systems support in place for disease control, prevention, treatment, surveillance, risk assessment and risk communications	✓	!	✓	!	✓	✓	✓

Budget and expenditure by major office, 2014–2015 (US$ 000)

	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Health Assembly-approved budget	4 800	3 800	3 800	1 400	3 500	8 000	43 200	68 500
Funds available (as at 31 December 2015)								
Flexible funds	3 057	2 644	1 144	1 075	3 854	1 657	13 267	26 698
Voluntary contributions specified	5 310	757	3 886	4 307	5 140	7 777	26 324	53 501
Total	**8 367**	**3 401**	**5 030**	**5 382**	**8 994**	**9 434**	**39 591**	**80 199**
Funds available as a % of budget	174%	90%	132%	384%	257%	118%	92%	117%
Staff costs	5 697	1 925	1 474	2 440	3 182	4 161	26 157	45 036
Activity costs	4 759	1 176	3 040	2 673	4 773	4 618	10 540	31 579
Total expenditure	**10 456**	**3 101**	**4 514**	**5 113**	**7 955**	**8 779**	**36 697**	**76 615**
Expenditure as a % of approved budget	218%	82%	119%	365%	227%	110%	85%	112%
Expenditure as a % of funds available	125%	91%	90%	95%	88%	93%	93%	96%
Staff expenditure by major office	13%	4%	3%	5%	7%	9%	58%	100%

5.3 EMERGENCY RISK AND CRISIS MANAGEMENT

OUTCOME 5.3. COUNTRIES HAVE THE CAPACITY TO MANAGE PUBLIC HEALTH RISKS ASSOCIATED WITH EMERGENCIES

Safe Hospitals Initiative

Health facilities, especially hospitals, are critical assets for communities both routinely and especially in response to emergencies, disasters and other crises. Yet hospitals and health workers are often among the major casualties of emergencies, with the result that health services cannot be provided to affected communities when they are most needed.

As a means of ensuring that the most critical health services are available when they are most needed, WHO, together with global, national and local partners, has implemented the Safe Hospitals Initiative. The vision of this initiative is “to protect the lives and health of people during emergencies and disasters”.

The Comprehensive Safe Hospital Framework was developed and published by WHO in collaboration with other partners to provide a structured approach for action taken to strengthen the safety and preparedness of hospitals and health facilities for all types of hazards. A global Hospital Safety Index tool was developed and rolled out, based on the Hospital Safety Index developed by WHO/PAHO, to allow countries to assess their hospitals with regard to their resilience to different types of hazards.

More than 77 countries have used the Hospital Safety Index to assess more than 3500 hospitals. In the last two years, additional countries have started applying the Hospital Safety Index tool, including the Islamic Republic of Iran, Japan and the Solomon Islands. The scope of the safe hospital work has expanded to align with related programmes such as climate change and environmental health. In the Caribbean, this has been translated into

the Smart Hospital concept that brings safe and green aspects together. This concept is being expanded to island States in the Western Pacific Region and some countries in the South-East Asia Region. Under this initiative, many countries have retrofitted hospitals and ensured that new hospitals have been built according to recognized standards. Measures to ensure the functionality of health facilities through training courses, stockpiling of essential supplies, networking with national and international coordination mechanisms for disaster response, and other efforts have been put in place. An international campaign on safe hospitals garnered much attention from countries, resulting in several regional and global resolutions.

To make a hospital safe and resilient requires efforts from both traditional and non-traditional health partners, including architects, structural engineers, electricians and masons, as well as health workers, government officials and other officials. Coordination with incoming medical teams is also a critical aspect of the Safe Hospitals Initiative.

The impact of the Safe Hospitals Initiative was identified in various hazardous situations.

- 2001 Gujarat earthquake: following the earthquake, Gujarat State in India rebuilt all of its hospitals to be earthquake resilient with technical support from WHO.
- 2010 Chile earthquake: in March 2010, an earthquake of magnitude 9.0 on the Richter scale struck Chile. Chile had invested substantially in making its health facilities safe in the face of earthquakes. As a result, no hospital lost its functions in the aftermath of the earthquake, being able to deliver critical health services to the affected population.
- Nepal earthquakes 2015: In preparedness for a large-scale earthquake, major hospitals in Kathmandu Valley were retrofitted with technical and financial support from WHO and health cluster partners. They all survived and were able to deliver critical health care following the earthquakes in 2015.

These examples show that the right level of investments from all partners, including WHO, national and local governments, international and national health partners, and other networks have resulted in a programme that has contributed to achieving the category 5 impact statement of “prevention of death, illness and disability arising from emergencies” by ensuring the availability of life-saving health care in times of need.

The above is an illustration of the work that has been done under programme area on emergency risk and crisis management. The table below shows overall output achievements by major office. For more detailed information on the work implemented under this programme area including explanations of output ratings, please consult the programme budget web portal.

(✓)Fully delivered/contributed (!) Partly delivered/contributed (X) Not delivered/contributed (n/a) Not applicable								
Output		Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
5.3.1.	Global Health Cluster and country health clusters reformed in line with the United Nations Inter-Agency Standing Committee's transformative agenda	!	✓	✓	✓	✓	✓	!
5.3.2.	Health established as a central component of global multisectoral frameworks for emergency and disaster risk management; national capacities strengthened for all-hazard emergency and disaster risk management for health	!	✓	✓	✓	✓	✓	!
5.3.3.	Organizational readiness successfully realized for full implementation of WHO's Emergency Response Framework	!	✓	✓	✓	!	✓	!
5.3.4.	Health sector strategy and plan developed, implemented and reported on in all targeted protracted-emergency countries by an in-country network of qualified and trained WHO emergency staff	!	✓	✓	✓	✓	✓	!

Budget and expenditure by major office, 2014–2015 (US$ 000)

	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Health Assembly-approved budget	37 700	3 200	6 000	3 400	7 300	4 000	26 400	88 000
Funds available (as at 31 December 2015)								
Flexible funds	13 563	2 038	2 928	2 051	3 354	1 431	9 855	35 220
Voluntary contributions specified	18 373	2 746	2v874	825	12 225	1 101	16 431	54 584
Total	**31 936**	**4 784**	**5 802**	**2 876**	**15 579**	**2 532**	**26 286**	**89 804**
Funds available as a % of budget	85%	150%	97%	85%	213%	63%	100%	102%
Staff costs	13 709	1 902	3 279	1 864	11 114	1 057	22 673	55 598
Activity costs	14 706	2 962	2 335	975	5 699	1 366	3 569	31 612
Total expenditure	**28 415**	**4 864**	**5 614**	**2 839**	**16 813**	**2 423**	**26 242**	**87 210**
Expenditure as a % of approved budget	75%	152%	94%	84%	230%	61%	99%	99%
Expenditure as a % of funds available	89%	102%	97%	99%	108%	96%	100%	97%
Staff expenditure by major office	25%	3%	6%	3%	20%	2%	41%	100%

5.4 FOOD SAFETY

OUTCOME 5.4. ALL COUNTRIES ARE ADEQUATELY PREPARED TO PREVENT AND MITIGATE RISKS TO FOOD SAFETY

Five keys to safer food – simple messages

Diseases that people get from eating contaminated food are an important cause of illness, disability and deaths around the world, as revealed by the first-ever WHO estimates of the global burden of foodborne diseases, published in December 2015. People in every part of the world are affected, and children under five years of age and people in low-income areas are hit hardest. Foodborne diseases – especially those caused by bacteria, viruses, parasites and fungi – are preventable, and education in how to prepare and store food safely is a key measure for prevention.

The Five Keys to Safer Food were first developed in 2001 when WHO identified the need for a simple, global health message to empower all food handlers, including consumers. Countries adopted the Five Keys immediately, and over the past 15 years they have become the go-to international reference. The Five Keys to Safer Food poster is now available in 90 languages.

In 2015, WHO dedicated its flagship event – World Health Day – to food safety. Through the campaign "How safe is your food? From farm to plate, make food safe", WHO called on governments, the public and actors in human and animal health, agriculture, trade, environment and education to join forces to prevent and control foodborne diseases. In addition to a global launch event at the world's largest fresh food market near Paris, France, all of WHO's six regional offices and many country offices brought together regional and national partners at dedicated events on food safety. All three levels of the Organization worked together with external partners, including FAO and OIE, to spread the WHO Five Keys to Safer Food to as many people as possible around the globe.

To complement existing Five Key materials, in 2015 WHO produced an educational animated movie to explain the Five Keys principles to audiences aged nine to 99 years in a catchy and humorous style. It was embraced by countries, and fast became one of the most-watched videos on WHO's YouTube channel. Within months it had been translated into more than a dozen languages. Other new materials such as t-shirts, bookmarks, and magnets with the Five Keys messages, and visuals from the video, were also developed and adopted by regions and countries. The successes of the Five Keys and World Health Day 2015 are largely due to the willingness of Member States to mainstream food safety in the public health agenda. The large number of activities undertaken by countries, ranging from television spots to cooking demonstrations, shows the impact and usefulness of a simple, global health message that is easy to adopt in and adapt to local settings.

Another way in which WHO promoted the Five Keys in 2015 was through participation in the Expo in Milan, Italy, the theme of which was food. In collaboration with the Swiss Pavilion, WHO organized workshops where participants could learn to make their own chocolate while learning and practicing the Five Keys.

Over the past 15 years, through training and health promotion campaigns, food handlers and consumers all over the world have learnt how to protect their health and that of their families and communities. They include people who may not otherwise have had access to food safety education, despite the important role they have in producing safe food, such as rural women. Countries now have access to a range of tools, experiences and tested solutions to cost-effectively integrate food safety education into their programmes to decrease the global burden of foodborne diseases.

The Five Keys to Safer Food have already contributed to the prevention of foodborne diseases and deserve to be communicated more widely. Improving food safety contributes to improved community health and achievement of the Sustainable Development Goals to reduce child deaths and poverty, improve nutrition and food security, and empower women. Continued involvement of partners in implementation of the Five Keys is essential to success in these areas and sustainable development.

The above is an illustration of the work that has been done under programme area on food safety and shows the value of one of WHO's core functions, namely that of providing continued long-term leadership on matters critical to health. The table below shows overall output achievements by major office. For more detailed

information on the work implemented under this programme area including explanations of output ratings, please consult the programme budget web portal.

(✓)Fully delivered/contributed (!) Partly delivered/contributed (X) Not delivered/contributed (n/a) Not applicable								
Output		**Africa**	**Americas**	**South-East Asia**	**Europe**	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**
5.4.1.	Support the work of the Codex Alimentarius Commission to develop, and for countries to implement, food safety standards, guidelines and recommendations	✓	!	!	✓	✓	✓	!
5.4.2.	Multisectoral collaboration to reduce foodborne public health risks, including those arising at the animal–human interface	✓	✓	!	✓	✓	✓	✓
5.4.3.	Adequate national capacity to establish and maintain risk-based regulatory frameworks to prevent, monitor, assess and manage foodborne and zoonotic diseases and hazards	✓	✓	!	✓	✓	✓	✓

Budget and expenditure by major office, 2014–2015 (US$ 000)

	Africa	**Americas**	**South-East Asia**	**Europe**	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**	**Total**
Health Assembly-approved budget	4 600	2 900	800	1 400	1 400	2 300	19 100	32 500
Funds available (as at 31 December 2015)								
Flexible funds	1 416	687	247	716	1 633	1 194	7 516	13 409
Voluntary contributions specified	145	425	0	227	0	214	8 485	9 498
Total	**1 561**	**1 112**	**247**	**943**	**1 633**	**1 408**	**16 001**	**22 907**
Funds available as a % of budget	34%	38%	31%	67%	117%	61%	84%	70%
Staff costs	85	130	96	528	1 131	365	8 885	11 220
Activity costs	525	778	469	403	881	1 054	6 377	10 487
Total expenditure	**610**	**908**	**565**	**931**	**2 012**	**1 419**	**15 262**	**21 707**
Expenditure as a % of approved budget	13%	31%	71%	67%	144%	62%	80%	67%
Expenditure as a % of funds available	39%	82%	229%	99%	123%	101%	95%	95%
Staff expenditure by major office	1%	1%	1%	5%	10%	3%	79%	100%

5.5 POLIO ERADICATION

OUTCOME 5.5. NO CASES OF PARALYSIS DUE TO WILD OR TYPE-2 VACCINE-RELATED POLIOVIRUS GLOBALLY

Polio – the Endgame

The Polio Eradication Endgame Strategic Plan (the Endgame) was developed in response to the Health Assembly's declaration in May 2012 that completion of poliovirus eradication was a "programmatic emergency for global public health". Today, of the three strains of wild poliovirus – types 1, 2 and 3 – only wild poliovirus type 1 is still seen in circulation, and it is endemic to only two countries.

This impressive progress towards full eradication of polio can largely be attributed to the oral polio vaccine – the most effective vaccine in our arsenal today against wild poliovirus. However, as oral polio vaccine is made with live attenuated (weakened) polioviruses, in very rare cases (approximately 1 out of every 2.7 million people vaccinated) it can result in a case of vaccine-associated paralytic polio. In addition, under certain conditions, a strain of poliovirus in the oral polio vaccine may change and revert to a form that may be able to cause paralysis (vaccine-derived poliovirus) in humans and, in such cases, develop the capacity for sustained circulation. The latter is known as circulating vaccine-derived poliovirus. Between 2000 and 2016, oral polio vaccine type 2 was responsible for 86% of the circulating vaccine-derived poliovirus cases and over 40 of the vaccine-associated paralytic polio cases. While oral polio vaccine is still a critical tool in the fight to eradicate polio, it has become increasingly clear that there is a need to withdraw the type 2 component.

In September 2015, the Global Certification Commission concluded that wild type 2 poliovirus had been eradicated, setting the stage for the final withdrawal of oral polio vaccine type 2. All of the 155 countries and territories still using oral polio vaccine type 2 have committed to stopping its use in a globally synchronized manner in April 2016. In preparation for oral polio vaccine type 2 global withdrawal, support has been provided to enable introduction of one dose of inactivated polio vaccine into the routine immunization programmes of 126 of the countries that were using oral polio vaccine as the only polio vaccine within their national immunization programmes.

The withdrawal of oral polio vaccine type 2 and introduction of inactivated polio vaccine will have a major health impact through the reduction of vaccine-associated paralytic polio and circulating vaccine-derived poliovirus type 2 cases, thereby reducing both morbidity and mortality.

Furthermore, through the introduction of inactivated polio vaccine into routine immunization programmes and as part of preparations for global oral polio vaccine type 2 withdrawal, countries have been able to strengthen their broader immunization programmes nationwide. Activities such as refresher training courses, increased supervisory visits, new immunization cards and strengthening of the cold chain have all been undertaken through funding provided to support inactivated polio vaccine introduction and oral polio vaccine type 2 withdrawal.

As at the end of 2015, all 126 countries using oral polio vaccine only had committed to introducing inactivated polio vaccine, and 80 countries – including all high-risk countries – had already done so. The delays in the remaining country introductions are due to global inactivated polio vaccine supply constraints. Out of the 155 Member States that need to withdraw oral polio vaccine type 2, 140 had developed oral polio vaccine type 2 withdrawal plans, outlining the steps to be taken to switch from trivalent to bivalent oral polio vaccine in routine immunization programmes and to destroy any remaining trivalent oral polio vaccine stocks (i.e. those which contain oral polio vaccine type 2).

In addition, polio-funded staff are contributing to strengthening health systems across a wide range of countries. Studies conducted in 2014 and 2015 showed that, in 10 countries with large teams of polio-funded staff in Asia and Africa, these personnel spend, on average 46% of their time supporting routine immunization activities (i.e. new vaccine introduction, child health days, measles campaigns, etc.) and a further 8% of their time supporting the broader health system (i.e. other humanitarian responses, maternal health initiatives, etc.).

The impact of these contributions can be clearly seen when looking at Nigeria's response to the 2014 Ebola outbreak. Nigeria's multipartner Emergency Operations Centre, established to coordinate polio eradication activities, was able to rapidly switch gears and coordinate the Ebola response. Polio-funded field staff played critical roles in case investigations and in surveillance activities, roles they were trained to do through their polio eradication work. The availability of trained staff and existing infrastructure on the ground has widely been credited with playing a critical role in halting the spread of Ebola and in minimizing the loss of lives in Nigeria.

The above is an illustration of the work that has been done under programme area on polio eradication and shows how staff adequately trained in basic public health disciplines such as surveillance can be rapidly deployed from one disease to another at times of acute crisis.

The table below shows overall output achievements by major office. For more detailed information on the work implemented under this programme area including explanations of output ratings, please consult the programme budget web portal.

(✓)Fully delivered/contributed (!) Partly delivered/contributed (X) Not delivered/contributed (n/a) Not applicable								
Output		**Africa**	**Americas**	**South-East Asia**	**Europe**	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**
5.5.1.	Direct support to raise population immunity against polio to the required threshold levels in affected and high-risk areas	✓	✓	✓	!	✓	✓	✓
5.5.2.	International consensus established on the cessation of the use of oral polio vaccine type 2 in routine immunization programmes globally	✓	✓	✓	✓	✓	✓	✓
5.5.3.	Processes established for long-term poliovirus risk management, including containment of all residual polioviruses, and the certification of polio eradication globally	!	✓	✓	✓	✓	✓	✓
5.5.4.	Establishment of the polio legacy plan	!	✓	✓	✓	✓	✓	!

Budget and expenditure by major office, 2014–2015 (US$ 000)

	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Health Assembly-approved budget	408 200	3 500	69 600	4 000	140 100	1 900	73 100	700 400
Funds available (as at 31 December 2015)								
Flexible funds	7 547	0	263	31	18	32	10	7 901
Voluntary contributions specified	659 723	1 282	76 587	5 447	257 643	7 741	120 812	1 154 760
Total	**667 270**	**1 282**	**76 850**	**5 478**	**257 661**	**7 773**	**120 822**	**1 162 661**
Funds available as a % of budget	163%	37%	110%	137%	184%	409%	165%	166%
Staff costs	134 433	171	4 443	1 636	24 874	1 020	30 703	197 280
Activity costs	476 912	802	62 487	2 921	206 179	5 729	67 728	822 758
Total expenditure	**611 345**	**973**	**66 930**	**4 557**	**231 053**	**6 749**	**98 431**	**1 020 038**
Expenditure as a % of funds available	92%	76%	87%	83%	90%	87%	81%	88%
Staff expenditure by major office	68%	0%	2%	1%	13%	1%	16%	100%

5.6 OUTBREAK AND CRISIS RESPONSE

OUTCOME 5.6. ALL COUNTRIES ADEQUATELY RESPOND TO THREATS AND EMERGENCIES WITH PUBLIC HEALTH CONSEQUENCES

2014–2015 marked an unprecedented number of health crises

In 2014–2015, WHO experienced an unprecedented number of health crises with demands to respond to multiple, simultaneous large-scale outbreaks and emergencies. These included infectious diseases such as Middle East respiratory syndrome coronavirus, avian influenza A(H5N1) and A(H7N9) viruses, cholera, yellow fever and the outbreak of Ebola virus disease in West Africa; natural disasters such as typhoon Haiyan in the Philippines and the earthquake in Nepal; as well as protracted conflict situations in the Central African Republic, Iraq, South Sudan, the Syrian Arab Republic and Yemen.

The outbreak of Ebola virus in West Africa (first cases notified in March 2014), was the largest and most complex Ebola outbreak since the virus was first discovered in 1976. There have been more cases and deaths in this outbreak than in all others combined. It spread between countries, starting in Guinea and moving across land borders to Sierra Leone and Liberia, then by air (one traveller) to Nigeria and the United States (one traveller) and by land to Senegal (one traveller) and Mali (two travellers).

The most severely affected countries, Guinea, Liberia and Sierra Leone, have very weak health systems, lack human and infrastructural resources, and have only recently emerged from long periods of conflict and instability. The outbreak was so severe that the WHO Director-General declared the West Africa outbreak a Public Health Emergency of International Concern under the International Health Regulations (2005). Worldwide, there have been 28 639 cases of Ebola virus disease and 11 316 deaths (as at 13 March 2016).

The outbreak of Ebola in West Africa was only one of several epidemics experienced recently; the others include four major outbreaks of Middle East respiratory syndrome in Saudi Arabia and the Republic of Korea, the pandemics of H1N1 and H5N1 influenza, and severe acute respiratory syndrome. All serve as a stark

reminder of the threat to humanity posed by emerging communicable diseases, particularly in vulnerable and low resource settings.

Such was the global impact of the Ebola outbreak that the United Nations Secretary-General appointed a High-level Panel on the Global Response to Health Crises, chaired by Jakaya Mrisho Kikwete, former President of United Republic of Tanzania, to propose recommendations on strengthening national and international systems to prevent and respond effectively to future health crises, taking into account lessons learnt from the Ebola response.

Moreover, due to the enormous demand on WHO to respond to all these crises, a special session of the Health Assembly was held in 2015, after which the Director-General announced the establishment of an Advisory Group to guide her on the issue of WHO emergency reform. The goal of the reform process was to strengthen and consolidate the Organization's capacities to respond to, and prepare for, all manner of crises that have an impact on people's health and disrupt the delivery of health care services.

During 2015, on the advice of Director-General's Advisory Group, a new cluster for Outbreaks and Health Emergencies was formed with the remit of designing, building and implementing a new WHO emergencies programme, based on aligned recommendations from advisory groups. Key elements of reform for the new WHO Programme for Outbreaks and Emergencies will be prioritized including infectious hazard management; Member State preparedness; risk assessment and information management; operational partnerships and readiness; and emergency operations.

Adequate, sustained political and financial support for WHO's new Programme on Outbreaks and Health Emergencies is now critical for it to perform its core functions including: rapid assessment of health risks to inform Member States and the public; provision of technical leadership and advice on all health matters; maintenance of a field presence to support Member States in preparedness for, and response to, all health emergencies.

The WHO Contingency Fund for Emergencies is designed to allow WHO to assess risks and rapidly scale up its initial response to outbreaks and emergencies in the critical, time-limited period before strategic plans are developed and funded, when no other cash flow is available. In addition, WHO is collaborating with the World Bank on the Pandemic Emergency Facility, intended to finance Member States and partners in the response to a declared health emergency.

The above is an illustration of the work that has been done under programme area on outbreak and crisis response. The table below shows overall output achievements by major office. For more detailed information on the work implemented under this programme area, including explanations of output ratings, please consult the programme budget web portal.

(✓)Fully delivered/contributed (!) Partly delivered/contributed (X) Not delivered/contributed (n/a) Not applicable								
Output		**Africa**	**Americas**	**South-East Asia**	**Europe**	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**
5.6.1.	Implementation of the WHO's Emergency Response Framework in acute emergencies with public health consequences	!	✓	✓	✓	✓	✓	!

Budget and expenditure by major office, 2014–2015 (US$ 000)

	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Health Assembly-approved budget	39 300	7 600	5 200	5 000	151 200	5 000	14 200	227 500
Funds available (as at 31 December 2015)								
Flexible funds	1 610	16	2 217	0	3 812	138	21 424	29 217
Voluntary contributions specified	267 160	6 838	16 032	15 430	266 386	20 126	152 383	751 653
Total	**268 770**	**6 854**	**18 249**	**15 430**	**270 198**	**20 264**	**173 807**	**780 870**
Funds available as a % of budget	684%	90%	351%	309%	179%	405%	1224%	343%
Staff costs	5 763	611	605	2 128	18 319	1 804	28 602	57 832
Activity costs	222 757	5 951	15 180	10 600	223 654	18 226	121 925	618 293
Total expenditure	**228 520**	**6 562**	**15 785**	**12 728**	**241 973**	**20 030**	**150 527**	**676 125**
Expenditure as a % of funds available	85%	96%	86%	82%	90%	99%	87%	87%
Staff expenditure by major office	10%	1%	1%	4%	32%	3%	49%	100%

Category 6

CORPORATE SERVICES/ENABLING FUNCTIONS

Corporate services and enabling functions provide the organizational leadership and joint resources needed to maintain the integrity and efficient functioning of WHO.

Progress was shown on the three main objectives of the WHO reform initiated in 2011: (i) greater coherence in global health; (ii) improved health outcomes; and (iii) an Organization that pursues excellence. During 2014–2015, most of the defined WHO reform outputs moved to the implementation stage and with the development of a robust monitoring framework it became possible to monitor the impact of the reform over time through a performance metrics.

The biennium set out to focus on organizational effectiveness with particular emphasis on managerial accountability, transparency and risk management.

Achievements of particular note include the establishment of an independent evaluation function, reporting to the Director-General. The internal justice system was subject to an in-depth review and an implementation plan accepted to implement the recommendations.

The biennium saw massive work rolled out in the human resources area with the implementation of the three pillars of the human resources strategy, resulting, among other achievements, in the adoption of a geographical mobility framework.

With the establishment of the office of Compliance, Risk management and Ethics the biennium saw several initiatives completed that strengthen accountability, such as the whistleblower policy and WHO's risk management policy and framework.

The planning process for the Programme budget 2016–2017 was revised to strengthen the Organization's planning and financing cycle towards more effective and efficient delivery of outputs and to illustrate their contribution to improved health outcomes.

Much has been achieved, but in the last year of the biennium operations in this area were marked by the Ebola virus outbreak and the ensuing initiative to reform the work of WHO in outbreaks and health emergencies, and this resulted in delays in some areas. Certain reform initiatives relating to information management and the planned review of hosted partnerships were among the activities to have been delayed.

CATEGORY 6 OVERALL FINANCIAL SUMMARY, 2014–2015 (US$ 000) *(including post occupancy charge)*

	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Health Assembly-approved budget	154 000	48 400	57 200	63 100	80 600	51 300	368 400	823 000
Funds available (as at 31 December 2015)								
Flexible funds	131 516	34 172	49 437	49 062	60 994	44 565	263 993	633 739
Voluntary contributions specified	4 429	30	339	1 112	758	2 456	10 797	19 921
Post occupancy charge	23 026	4 098	5 820	9 393	9 025	7 125	76 178	134 665
Total	**158 971**	**38 300**	**55 596**	**59 567**	**70 777**	**54 146**	**350 968**	**788 325**
Funds available as a % of budget	103%	79%	97%	94%	88%	106%	95%	96%
Staff costs	107 296	18 827	32 336	43 864	47 142	35 809	238 399	523 673
Activity costs	42 280	19 929	21 450	14 773	21 390	17 335	100 335	237 492
Total expenditure	**149 576**	**38 756**	**53 786**	**58 637**	**68 532**	**53 144**	**338 734**	**761 165**
Expenditure as a % of approved budget	97%	80%	94%	93%	85%	104%	92%	92%
Expenditure as a % of funds available	94%	101%	97%	98%	97%	98%	97%	97%
Staff expenditure by major office	20%	4%	6%	8%	9%	7%	46%	100%

6.1 LEADERSHIP AND GOVERNANCE

OUTCOME 6.1. GREATER COHERENCE IN GLOBAL HEALTH, WITH WHO TAKING THE LEAD IN ENABLING THE MANY DIFFERENT ACTORS TO PLAY AN ACTIVE AND EFFECTIVE ROLE IN CONTRIBUTING TO THE HEALTH OF ALL PEOPLE

WHO's efforts in the areas of leadership and governance towards fulfilling its constitutional mandate to act as the directing and coordinating authority for international health matters were most significantly reflected in the work undertaken in 2014–2015 related to:

In response to the Ebola virus disease outbreak in West Africa, WHO established the largest emergency operation in its history. More than 1000 staff members were deployed across more than 60 field sites in the three main affected countries of Guinea, Liberia and Sierra Leone. In total, across all West African countries that experienced active transmission of Ebola, more than 2200 technical experts were deployed by WHO, including more than 950 experts from partners in the Global Outbreak Alert and Response Network. In addition, WHO produced more than 50 technical guidance documents covering a broad range of public health and clinical topics.

WHO also facilitated the review and consideration of numerous vaccines, medicines, therapies and diagnostic tools for the treatment and detection of Ebola virus disease. Accelerated review procedures have allowed the fast-tracking of several of these vaccines and diagnostics.

WHO has supported each of the three affected countries in developing national recovery and resilience plans outlining strategies for the safe reactivation of essential health services and longer-term health system functions.

Recent events showed that there was a need to reform WHO's capacity to respond to health emergencies as part of a strengthened international system for global health security and disaster response. The reform initiatives include the establishment of a WHO new Programme on Outbreaks and Health Emergencies based on an organizational structure across the three levels of WHO with clear authority to facilitate rapid and transparent decision-making and action. Streamlined management processes and tools have also been established to facilitate a rapid and effective response, including human resources, planning and budgeting, financial resource management, and logistics.

There is also a need to provide intensified support to countries in developing priority International Health Regulations (2005) core capacities as an integral part of resilient health systems, to enable rapid detection of, and effective response to, disease outbreaks and other hazards, as well as providing people-centred health care based on primary health care.

For the reform to be effective, adequate international financing for pandemics and other health emergencies must be available through a number of channels including the Contingency Fund for Emergencies, which is part of an international financing system. Likewise, a research and development blueprint will be developed to expedite development of essential health technologies/commodities in the context of emergencies.

In 2014–2015, much work was undertaken in engaging in international negotiations to ensure that health dimensions were appropriately reflected in the formulation of the Sustainable Development Goals. In part due to the efforts of WHO, the Sustainable Development Goals reflect a strong integration of the health-related targets, and the positioning of universal health coverage as central to all the health targets is considered a major achievement for the health community.

While engaging in the process of finalizing the 2030 Sustainable Development Goals, WHO has also moved swiftly in helping to prepare and support countries in implementing the Sustainable Development Goals agenda through ongoing work including: strengthening WHO's own capacity at country level; supporting countries to incorporate the health-related Goal and its targets in national development agendas and to monitor the progress towards the Goal and targets; and engaging with relevant health and development partners to align efforts around the health-related targets of the Sustainable Development Goals.

In 2014–2015, the focus has been on strengthening the leadership and capacity of WHO's presence in countries in support of the health and development priorities of Member States.

The revised country cooperation strategies guide was developed as a collaboration between the three levels of the Organization, taking into account WHO leadership priorities. The renewed country cooperation strategies guide has been rolled out through orientation workshops organized in the regions. As a result, the country cooperation strategies that were developed or updated in 2015 are more focused and present more realistic strategic agendas that are better aligned with national health priorities.

The outcomes stemming from WHO's Eighth Global Meeting of Heads of Country Offices strengthened leadership and stewardship of WHO's work, including the management and coordination of work across the three levels of the Organization.

Concerted efforts have been undertaken in countries with a WHO presence to ensure close partnership with the respective health authorities, other government sectors, United Nations agencies and other relevant partners towards achievement of priority health outcomes.

In 2014–2015, work has continued to improve WHO's internal governance processes and mechanisms and also to engage externally with partners and relevant stakeholders that have an impact on public health.

The Health Assembly, Executive Board and its committees, and intergovernmental processes mandated by them, were managed and administered in the official languages, including through the issuance of the required documentation and provision of interpretation. There was greater access to online documentation, webcasting of the Executive Board and Health Assembly sessions, and an increase in the number of preparatory mission briefings, with remote access via WebEx for regional and country offices and capitals. Due to the increase in the number of governing body agenda items, and consequent increase in the number of documents to be prepared, the late issuance of some of the governing body documentation was noted.

Member State negotiations continue on a framework of engagement for non-State actors. The overarching framework is intended to apply to WHO's engagement with non-State actors and provides the rationale, principles and boundaries of such engagement. This framework will have important implications for the operational arrangements and mechanisms that WHO will employ in engaging with non-State actors towards improvement of public health outcomes.

The above is an illustration of the work that has been done under programme area on leadership and governance. The table below shows overall output achievements by major office. For more detailed information on the work implemented under this programme area including explanations of output ratings, please consult the programme budget web portal.

(✓)Fully delivered/contributed (!) Partly delivered/contributed (X) Not delivered/contributed (n/a) Not applicable								
Output		**Africa**	**Americas**	**South-East Asia**	**Europe**	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**
6.1.1.	Effective WHO leadership and management in place	✓	!	✓	✓	!	✓	✓
6.1.2.	Effective engagement with other stakeholders in building a common health agenda that responds to Member States' priorities	✓	✓	✓	✓	✓	✓	✓
6.1.3.	WHO governance strengthened with effective oversight of the sessions of the governing bodies, and efficient, aligned agendas	✓	✓	✓	✓	✓	✓	!
6.1.4.	Integration of WHO reform into the work of the Organization	!	✓	✓	✓	✓	✓	!

Budget and expenditure by major office, 2014–2015 (US$ 000) *(including post occupancy charge)*

	Africa	**Americas**	**South-East Asia**	**Europe**	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**	**Total**
Health Assembly-approved budget	47 500	17 700	14 300	25 300	22 800	17 100	83 000	227 700
Funds available (as at 31 December 2015)								
Flexible funds	40 051	4 315	13 297	24 856	16 300	15 547	73 339	187 705
Voluntary contributions specified	2 710	0	106	605	602	1 183	6 836	12 042
Post occupancy charge	0	0	0	0	0	0	150	150
Total	**42 761**	**4 315**	**13 403**	**25 461**	**16 902**	**16 730**	**80 325**	**199 897**
Funds available as a % of budget	90%	24%	94%	101%	74%	98%	97%	88%
Staff costs	33 995	3 288	10 399	22 353	15 399	14 305	64 112	163 851
Activity costs	8 124	1 105	2 965	3 019	1 082	1 912	15 186	33 393
Total expenditure	**42 119**	**4 393**	**13 364**	**25 372**	**16 481**	**16 217**	**79 298**	**197 244**
Expenditure as a % of approved budget	89%	25%	93%	100%	72%	95%	96%	87%
Expenditure as a % of funds available	98%	102%	100%	100%	98%	97%	99%	99%
Staff expenditure by major office	21%	2%	6%	14%	9%	9%	39%	100%

6.2 TRANSPARENCY, ACCOUNTABILITY AND RISK MANAGEMENT

OUTCOME 6.2. WHO OPERATES IN AN ACCOUNTABLE AND TRANSPARENT MANNER AND HAS WELL-FUNCTIONING RISK-MANAGEMENT AND EVALUATION FRAMEWORKS

Effective managerial accountability, transparency and risk management is one of the key expected outcomes of the WHO reform and there has been continued progress in this regard. However, as noted by the Independent Expert Oversight Advisory Committee, the Organization appears to suffer from a culture of tolerance of non-compliance. This critique triggered a further intensification of activities to improve accountability over the biennium as described below.

To strengthen overall compliance, WHO has established compliance functions in the regions with a mandate to track transactions as well as to exercise a monitoring and oversight function for the regional offices and their country offices. As part of the internal control framework, over the course of 2015 the Organization rolled out the internal control management tools, including a self-assessment checklist and managers' guide, to foster managers' awareness of the adequacy of the control environment in their budget centres.

The Organization conducted the first risk management exercise across all levels of the Organization in accordance with a consistent and coherent methodology, and consolidated an Organization-wide, top-level register. The objective is to support informed decision-making and to embed risk management in all corporate operational processes.

Significant progress has been made to develop policies, procedures and tools to support the adoption of the WHO corporate risk management policy, which complements the bottom-up phase of risk identification and prioritization with a top-down phase of validation and escalation. The corporate risk management policy facilitates the identification, categorization, assessment, prioritization, mitigation and monitoring of risks and contributes to the promotion of the highest organizational standards for greater accountability and transparency. It provides the senior management with appropriate information about risks and establishes an effective reporting process.

WHO has taken steps to encourage adherence to core ethical values, which include the development and deployment of the WHO policy on whistleblowing and protection against retaliation, and, in parallel, a whistleblower hotline to be managed externally for the collation of wrongdoing and/or retaliation reports is in the process of being established.

WHO has developed and implemented a methodology to conduct administration and programme management reviews to improve the effectiveness and efficiency of country offices. Five such reviews were undertaken, in Ethiopia, Nepal, Indonesia, Myanmar and Ukraine.

An external quality review of the WHO internal audit function was assessed as achieving the highest status of "general conformity" with the recognized standards promulgated by the Institute of Internal Auditors. The capacity of internal audit and investigation functions was further strengthened through the filling of six vacant positions. However, due to the significant increase in reports of suspected wrongdoing during the same period, a significant backlog of investigations was noted at the end of 2015. It is also of note that the Independent Expert Oversight Advisory Committee has indicated that there has been continuous improvement in the implementation of open audit recommendations, particularly at the country office level.

In accordance with a risk-based approach, internal audit missions were undertaken in country and regional offices as well as in global cross-cutting areas, such as the direct financial cooperation modality. As a result of this work, the conclusions on the operating effectiveness of internal controls in country offices with satisfactory or partially satisfactory overall audit conclusions were found to have marginally improved during the biennium at 70% and 75% in 2014 and 2015, respectively. However, the conclusions on the operating effectiveness of internal controls at the regional offices and global cross-cutting areas were less favourable with either satisfactory or partially satisfactory overall audit conclusions assessed for only 60% and 50% of the audit missions in 2014 and 2015, respectively.

To accelerate progress in the implementation of the evaluation policy across the Organization and further support the continuing WHO reform process, an independent office for evaluation was established in August

2014. Building on lessons learnt across the United Nations system, a framework for strengthening evaluation and organizational learning in WHO was developed and adopted.

Two corporate evaluations were initiated in the second year of the biennium: The Ebola Interim Assessment Panel review, which presented its report to Member States in July 2015; and the evaluation of WHO's presence in countries, the report of which will be available early in 2016.

The findings of the Ebola interim assessment further informed and contributed to a number of other follow-up processes such as the United Nations Secretary-General's High-level Panel on the Global Response to Health Crises, the International Health Regulations (2005) Review Committee on Ebola, and the Director-General's Advisory Group on emergency reform.

The comprehensive evaluation of the global strategy and plan of action on public health, innovation and intellectual property was initiated in 2015 and will be completed by the end of 2016.

Technical backstopping and quality assurance were provided for decentralized evaluations. WHO also participated in joint United Nations evaluations, contributed to five reviews of the United Nations Joint Inspection Unit in 2015 (fraud prevention, internal audit, ombudsman services, acceptance of Joint Inspection Unit review recommendations, and succession planning), and facilitated independent external reviews of WHO commissioned by Germany, the Netherlands and the United Kingdom in 2015.

Regular reporting on the implementation of evaluation recommendations and tracking of management response will be included in the annual evaluation report to the Executive Board as well as being posted on the evaluation website.

The primary challenge in this programme area continues to be strengthening of the organizational culture towards accountability.

The above is an illustration of the work that has been done under programme area 6.2 on transparency, accountability and risk management. The table below shows overall output achievements by major office. For more detailed information on the work implemented under this programme area including explanations of output ratings, please consult the programme budget web portal.

(✓)Fully delivered/contributed (!) Partly delivered/contributed (X) Not delivered/contributed (n/a) Not applicable

Output		Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
6.2.1.	Accountability ensured though strengthened corporate risk management and evaluation at all levels of the Organization	✓	!	✓	✓	✓	✓	✓
6.2.2.	Implementation of WHO's evaluation policy across the Organization	!	✓	✓	✓	✓	✓	✓
6.2.3.	Ethical behaviour, decent conduct and fairness promoted across the Organization	!	!	✓	✓	✓	✓	✓

Budget and expenditure by major office, 2014–2015 (US$ 000) *(including post occupancy charge)*

	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Health Assembly-approved budget	7 300	4 600	1 000	1 100	1 400	100	34 900	50 400
Funds available (as at 31 December 2015)								
Flexible funds	2 986	801	1 317	1 944	672	51	21 148	28 919
Voluntary contributions specified	0	0	63	0	0	0	219	282
Post occupancy charge	0	0	0	0	0	0	700	700
Total	**2 986**	**801**	**1 380**	**1 944**	**672**	**51**	**22 067**	**29 901**
Funds available as a % of budget	41%	17%	138%	177%	48%	51%	63%	59%
Staff costs	2 095	661	910	1 946	829	23	19 758	26 222
Activity costs	747	80	519	24	8	27	3 777	5 182
Total expenditure	**2 842**	**741**	**1 429**	**1 970**	**837**	**50**	**23 535**	**31 404**
Expenditure as a % of approved budget	39%	16%	143%	179%	60%	50%	67%	62%
Expenditure as a % of funds available	95%	93%	104%	101%	125%	98%	107%	105%
Staff expenditure by major office	8%	3%	3%	7%	3%	0%	75%	100%

6.3 STRATEGIC PLANNING, RESOURCE COORDINATION AND REPORTING

OUTCOME 6.3. FINANCING AND RESOURCE ALLOCATION ALIGNED WITH PRIORITIES AND HEALTH NEEDS OF THE MEMBER STATES IN A RESULTS-BASED MANAGEMENT FRAMEWORK

Programmatic and financing reforms continued to strengthen the Organization's planning, budgeting and financing cycle towards more effective and efficient delivery of Member State-agreed outputs and to contribute to improved health outcomes. The Programme budget 2014–2015 was a realistic budget demonstrating a more coherent results chain and it gave greater clarity on the roles and responsibilities, as well defining a set of deliverables, for each of the levels of the Organization.

These improvements were further strengthened in the preparation of the Programme budget 2016–2017, building on reforms introduced in the Programme Budget 2014–2015. These reforms included a "bottom-up" planning process through regional and country consultations, complemented by a "top-down" process to identify global priorities expressed through resolutions of the governing bodies. This further strengthened the priority-driven, results-based budgeting process reflected in the identification by each country office of up to 10 priorities, to which 80% of planned results and resources would be directed. The work was grounded in Organization-wide planning that integrates the continuous work of the internal category and programme areas networks into programme budget development.

Consultations with Member States, coupled with the strengthened mechanisms mentioned above, resulted in shifts in programmatic emphasis for the proposed programme budget 2016–2017, reflecting continuing and emerging needs, including: the application of the lessons learnt from the outbreak of Ebola virus disease in West Africa; the response to discussions on the post-2015 development agenda, with a focus on universal health coverage, enhancing WHO's contribution to reproductive, maternal, newborn, child and adolescent

health, accelerating progress towards elimination of malaria, and expanding the work on prevention and control of noncommunicable diseases; and emerging threats and priorities, such as antimicrobial resistance, viral hepatitis, ageing and dementia. In addition, harmonization and standardization of budgeting methods have contributed to further refinement of the realistic proposed budget to accurately reflect expected costs for agreed organizational deliverables, as an important prerequisite to ensure that the programme budget functions as the primary tool for accountability for all managers in the Organization.

Programmatic reforms have further positioned the programme budget as the primary tool not only for programming WHO's work, but also for acting as the basis on which to measure WHO's performance through its delivery of outputs, and the instrument against which WHO's resources are mobilized and managed. The introduction of the financing dialogue in 2013 – a mechanism to facilitate Organization-wide coordinated resource mobilization, which incorporates strategic approaches to bilateral negotiations with contributors – promoted the key principles of WHO's financing reforms (namely, those of predictability, alignment, reduced vulnerability and greater transparency) as well as contributing to significant improvements in the financing of WHO. The process was repeated in 2015, enabling the Organization to commence the biennium 2016–2017 with a funding level of 83% of the base budget.

The approval of a unified programme budget and the revised programme budget web portal have significantly improved transparency, enabled better monitoring of resource flows, and have strengthened the Organization's communications around accountability, reporting on results and value for money.

Financing reforms aiming to strategically allocate flexible funds available to WHO (including core voluntary contributions and assessed contributions) have also made an important contribution to full financing of the programme budget. A strategic approach to the allocation of flexible funds across the Organization has ensured that all the programme areas have been fully operational throughout the biennium. The process of strategic release of these funds has been agreed across the Organization and builds on targeted, Organization-wide resource mobilization. Strategic use of flexible resources brings together several key aspects of resource management and the programme budget. First, more details on the funding gaps across the Organization are becoming apparent earlier in the biennium as a result of detailed analysis of current and future resources by programme area against the programme budget. Secondly, there is an agreed policy on the use of flexible resources, which aims to make up the shortfalls in the financing of the programme budget. As a result, the Secretariat can inform contributors of the current and future shortfalls against the programme budget, which could lead to a more open dialogue on how best to finance them. The introduction of a strategic approach to allocation of use of flexible funds across the Organization has resulted in better alignment and a reduced differential between least and best funded programmes and offices compared with 2012–2013.

However, some imbalances in funding levels across categories and programmes remain and more work is required to fully integrate and manage the use of strategic funds with coordinated resource mobilization needs. Coordination for resource mobilization has been improved but needs to be further structured through appropriate standard operational procedures and a common tool.

Through the creation of the department of Coordinated Resource Mobilization a more focused approach to resource mobilization has been implemented but needs to be further structured through appropriate standard operational procedures and common tools. However, all major offices have already reported taking action to improve capacity for resource mobilization at both regional and country level. Member States confirmed their support for the financing dialogue guiding principles of predictability, flexibility, alignment, transparency and broadening of the contributor base. Efforts in in the biennium have included gathering better global donor intelligence with the aim of widening the contributor base, and this endeavour has included input from all the regions.

The above is an illustration of the work that has been done under programme area on strategic planning, resource coordination and reporting. The table below shows overall output achievements by major office. For more detailed information on the work implemented under this programme area including explanations of output ratings, please consult the programme budget web portal.

(✓)Fully delivered/contributed (!) Partly delivered/contributed (X) Not delivered/contributed (n/a) Not applicable								
Output		Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
6.3.1.	Results-based management framework in place including an accountability system for WHO's corporate performance assessment	✓	✓	✓	✓	✓	✓	✓
6.3.2.	Alignment of WHO's financing with agreed priorities facilitated through strengthened resource mobilization, coordination and management	✓	✓	✓	✓	!	✓	✓

Budget and expenditure by major office, 2014–2015 (US$ 000)

	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Health Assembly-approved budget	5 200	600	5 700	3 400	2 800	4 000	12 800	34 500
Funds available (as at 31 December 2015)								
Flexible funds	4 264	2 326	2 102	2 735	2 065	6 256	10 125	29 873
Voluntary contributions specified	265	0	0	0	0	454	980	1 699
Total	**4 529**	**2 326**	**2 102**	**2 735**	**2 065**	**6 710**	**11 105**	**31 572**
Funds available as a % of budget	87%	388%	37%	80%	74%	168%	87%	92%
Staff costs	3 699	2 319	1 545	2 639	1 911	6 358	10 029	28 500
Activity costs	557	155	384	90	76	380	786	2 428
Total expenditure	**4 256**	**2 474**	**1 929**	**2 729**	**1 987**	**6 738**	**10 815**	**30 928**
Expenditure as a % of approved budget	82%	412%	34%	80%	71%	168%	84%	90%
Expenditure as a % of funds available	94%	106%	92%	100%	96%	100%	97%	98%
Staff expenditure by major office	13%	8%	5%	9%	7%	22%	35%	100%

6.4 MANAGEMENT AND ADMINISTRATION

OUTCOME 6.4. EFFECTIVE AND EFFICIENT MANAGEMENT ADMINISTRATION ESTABLISHED ACROSS THE ORGANIZATION

This programme area covers the core administrative service that are needed for effective and efficient functioning of WHO: finance, human resources, information technology and operations support.

The biennium has seen the introduction of many efficiency initiatives across all three levels of the Organization and this resulted in total expenditures being 7.5 % lower than the budget for 2014–2015. This has been achieved through a range of measures that include relocation of more corporate functions to Malaysia at lower costs than Geneva, reduction in travel, increased use of video and adoption of standardized globally shared IT products. Key achievements in 2014–2015 for the four management domains are noted below.

Finance

The focus in 2015 has been the reinforcement of internal controls, the development of new policies and the strengthening of current procedures, with a particular focus on country operations. One novelty has been the introduction of compliance dashboards as well as a new financial training initiative with the objective of ensuring competent administrative and financial knowledge at all three levels. More than 100 participants were trained in 2015.

WHO is sponsoring formal accreditation and other accounting certifications to finance staff in the Global Service Centre to both improve the technical expertise of finance staff but also to increase retention of staff and make WHO an employer of choice in the Malaysian setting.

On area of special emphasis has been strengthened compliance in the management of Direct Financial Cooperation(DFC) agreements, which are particularly numerous at country level and which have been a long-standing area of concern. Here good progress can be noted, with a decrease in outstanding Direct FinancialCooperation DFCreports from 15% in December 2013 to under 3% at the end of the biennium.

The biennium has also witnessed a higher level of reconciliation of Imprest accounts and a better response to audit recommendations, leading to their eventual closure, in particular at country level.

One key achievement has been the introduction of mobility, which has been much discussed in WHO and became a reality in this biennium. A managed geographical mobility scheme has been designed and endorsed, which applies to staff members in the professional and higher categories whose positions are designated as rotational. Following the support given by the governing bodies and the subsequent adoption of amendments to the Staff Rules and Staff Regulations, which provide a legal basis for the staffing of international rotational positions through annual mobility exercises, an implementation plan providing details of the main activities that need to be accomplished has been drafted.

The first compendium of posts offered for rotation was published in January 2016 with a three-year voluntary phase.

The harmonized selection process for international posts, which aims at ensuring consistency, efficiency and transparency through the introduction of a harmonized global competitive process for the selection of staff for longer-term positions in the professional and higher-level categories, was implemented.

The staff performance framework has been strengthened. This included release of guidance documents on “Recognizing and Rewarding Excellence” and “Managing Underperformance”.

To support performance management, an awareness programme was implemented using a variety of means such as distance learning and information sessions.

Development of corporate solutions and their implementation across the Organization has been the primary focus in 2014–2015. The implementation of shared services across the Organization progressed significantly in

some regions but less so in others. While the regional offices themselves have implemented a number of agreed shared services, the timing and completion of the roll out of these services to country offices vary. A number of constraints were faced, which were overwhelmingly related to funding, the state of local infrastructure and the availability of local support. However, all countries in the African, European, South-East Asia and Eastern Mediterranean regions, and some countries in the Western Pacific Region, have completed global email implementation and all countries in the African and South-East Asia regions, along with some in the European, Eastern Mediterranean and Western Pacific regions, have implemented managed firewalls. The identity and access management system was updated and is in use all countries and in all major offices.

The Global Management System Transformation project also faced a number of issues and some planned deployments of business processes and services were delayed. This was mainly related to repeated validation of business requirements with the technology initially chosen and delayed approval of relevant policies.

Additionally, priorities within IT were shifting. In the middle of 2014, in all country offices and in all major offices. IT became heavily involved in the Ebola response. Resources from headquarters and the regions were being deployed to affected countries. In the middle of 2015, senior IT resources were redirected from defined project/operational IT work to strategic engagements on how to make WHO an “emergency organization”.

The deteriorating security situation in many countries has prompted more offices to improve compliance with United Nations Minimum Operating Security Standards (MOSS). MOSS compliance is frequently modified owing to the changing security situation in each country. Full MOSS compliance is hence a moving target. During the biennium the security situation in several countries deteriorated, resulting in an associated increase in the MOSS requirements. Additional MOSS measures which had not been foreseen had to be introduced. This investment has enabled the overall achievement of this indicator but has created a strain on the security fund of the Organization. The increase in foreseen emergencies and immediate security responses also highlights the need for a sustainable mechanism for covering the costs related to security globally.

Procurement is a critical function that enables the Organization to effectively implement its mandate. The development of the WHO procurement strategy in 2015 identified the nature and scope of WHOs procurement operations (staff and non-staff contracts). This strategy emphasizes core procurement transactions for acquiring goods and services. It describes how to implement a procurement policy, which considers the existing principles of value for money, effective competition based on equal treatment, transparency and accountability, while reinforcing WHO’s commitment to environmentally responsible and socially responsible procurement.

The full implementation of the strategy will see further gains, especially in the area of improved supplier management and in enhancing collaboration with other United Nations agencies, with the aim of increasing value for money.

While the overall agenda set for this area was nearly fully implemented, it required ingenuity and a massive effort to deliver corporate services while also supporting the Ebola outbreak.

The above is an illustration of the work that has been done under programme areaon management and administration. The table below shows overall output achievements by major office. For more detailed information on the work implemented under this programme area including explanations of output ratings, please consult the programme budget web portal.

(✓)Fully delivered/contributed (!) Partly delivered/contributed (X) Not delivered/contributed (n/a) Not applicable								
Output		Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
6.4.1.	Sound financial practices managed through an adequate control framework, accurate accounting, expenditure tracking and the timely recording of income	✓	✓	✓	✓	✓	✓	✓
6.4.2.	Effective and efficient human resources management in place to recruit and support a motivated, experienced and competent workforce in an environment conducive to learning and excellence	!	✓	✓	✓	!	✓	✓
6.4.3.	Efficient and effective computing infrastructure, network and communications services, corporate and health-related systems and applications, and end-user support and training service provided	✓	✓	✓	✓	✓	✓	!
6.4.4.	Provision of operational and logistics support, procurement, infrastructure maintenance and asset management, and of a secure environment for WHO's staff and property (in compliance with United Nations Minimum Operating Security Standards (MOSS) and Minimum Operating Residential Security Standards (MORS))	!	✓	!	✓	!	✓	!

Budget and expenditure by major office, 2014–2015 (US$ 000) *(including post occupancy charge)*

	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Health Assembly-approved budget	88 700	22 400	35 600	30 500	50 700	26 800	218 600	473 300
Funds available (as at 31 December 2015)								
Flexible funds	80 789	24 510	31 096	15 472	39 536	19 602	137 466	348 471
Voluntary contributions specified	1 454	0	140	507	156	733	1 947	4 937
Post occupancy charge	23 026	4 098	5 820	9 393	9 025	7 125	75 328	133 815
Total	**105 269**	**28 608**	**37 056**	**25 372**	**48 717**	**27 460**	**214 741**	**487 223**
Funds available as a % of budget	119%	128%	104%	83%	96%	102%	98%	103%
Staff costs	65 104	10 370	18 423	13 268	26 872	12 772	125 867	272 676
Activity costs	31 990	18 436	17 077	11 246	19 947	14 098	77 102	189 896
Total expenditure	**97 094**	**28 806**	**35 500**	**24 514**	**46 819**	**26 870**	**202 969**	**462 572**
Expenditure as a % of approved budget	109%	129%	100%	80%	92%	100%	93%	98%
Expenditure as a % of funds available	92%	101%	96%	97%	96%	98%	95%	95%
Staff expenditure by major office	24%	4%	7%	5%	10%	5%	46%	100%

6.5 STRATEGIC COMMUNICATIONS

OUTCOME 6.5. IMPROVED PUBLIC AND STAKEHOLDERS' UNDERSTANDING OF THE WORK OF WHO

WHO social media: It's more than sharing WHO messages

Twitter is just one of the channels WHO uses to engage in public health conversations worldwide, interacting with those who comment about WHO's work in real time.

WHO began the biennium with a solid social media strategy based on the "one WHO" approach, whereby WHO headquarters maintains a single, corporate account on selected social media platforms, and does not allow individual programmes to initiate their own social media accounts. This has enabled WHO to steadily build and continue to expand a strong WHO social media presence. This has resulted in the Organization almost quadrupling its subscribers in the biennium 2014–2015.

In January 2014, the two main WHO social media channels – Twitter and Facebook – accounted together for almost 1.4 million subscribers. Two years later, that figure had risen to more than 5.3 million – with 2.7 million followers on Twitter and 2.67 million likes on Facebook by the end of 2015. Today, across WHO's 11 social media channels, the Organization has 6.74 million subscribers interested in receiving information about public health and interacting with WHO through social networks, meaning that WHO's public health messages reach millions of people worldwide every day.

The "one WHO" approach has also helped present a solid WHO social media voice during emergencies and outbreaks. WHO continues to use the exclusive feature of Twitter Alerts, which enable urgent tweets from the WHO account to be sent as text messages to users who wish to receive them. This is a useful feature in the context of emergencies where Internet connections may be fragile or non-existent.

In another example, during the Ebola outbreak in West Africa WHO saw the need to highlight hands-on "dos and don'ts" messages for the general public, as media monitoring showed that many questions were appearing on social media. Simple "graphic blocks" with these messages became an effective tool on Facebook to reach many people affected by the disease. One of the "graphic block" posts was liked by more than 14 000 Facebook users. These "graphic blocks" also came to the attention of *BBC Africa*. The channel redistributed these "graphic blocks" on the BBC Ebola WhatsApp service. As the biggest "chat app" in use in Africa, the platform is being used to reach people in the region directly through their mobile phones.

In 2015, WHO obtained Vine and Periscope accounts – video-based social media platforms. Vine allows WHO to show six-second videos with public health messages. On average, people will play a Vine video 6–7 times, so the platform provides another useful opportunity to reinforce WHO public health messages. By using these platforms, WHO keeps adapting to the new trend of social media video consumption and the reality that "shorter is better", to gain audience retention.

Wherever it can, WHO puts people at the heart of communications. So when illustrating the Organization's work on Ebola, WHO highlighted the people tackling the outbreak – from WHO staff to local doctors, from workers at the health incinerators to survivors.

Social media enables WHO to tap into topics that interest the general public. WHO's most retweeted tweet ever – which received almost 10 000 retweets – was about mental health. This is the second-most retweeted tweet in the history of the United Nations system. To put the figure in context: it received more retweets than any tweet from the UEFA Champions League's account, which has almost 11 million followers.

WHO set out to strengthen social media capacity at all levels in the biennium. All six regional offices now have Twitter accounts, with the South-East Asia and Western Pacific regions launching their social media presence during this biennium. Headquarters helped three country offices in countries experiencing emergencies or outbreaks to get started – Sierra Leone, Yemen and Ukraine. The aim now is to produce more content locally which can then be distributed globally.

The above is an illustration of the work that has been done under programme area on strategic communications. The table below shows overall output achievements by major office. For more detailed information on the work implemented under this programme area including explanations of output ratings, please consult the programme budget web portal.

(✓)Fully delivered/contributed (!) Partly delivered/contributed (X) Not delivered/contributed (n/a) Not applicable								
Output		**Africa**	**Americas**	**South-East Asia**	**Europe**	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**
6.5.1.	Improved communication by WHO staff leading to a better understanding of the Organization's action and impact	!	✓	✓	✓	!	!	!
6.5.2.	Development and efficient maintenance of innovative communication platforms	!	✓	✓	✓	!	✓	!

Budget and expenditure by major office, 2014–2015 (US$ 000)

	Africa	**Americas**	**South-East Asia**	**Europe**	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**	**Total**
Health Assembly-approved budget	5 300	3 100	600	2 800	2 900	3 300	19 100	37 100
Funds available (as at 31 December 2015)								
Flexible funds	3 426	2 220	1 625	4 055	2 421	3 109	21 915	38 771
Voluntary contributions specified	0	30	30	0	0	86	815	961
Total	**3 426**	**2 250**	**1 655**	**4 055**	**2 421**	**3 195**	**22 730**	**39 732**
Funds available as a % of budget	65%	73%	276%	145%	83%	97%	119%	107%
Staff costs	2 403	2 189	1 059	3 658	2 131	2 351	18 633	32 424
Activity costs	862	153	505	394	277	918	3 484	6 593
Total expenditure	**3 265**	**2 342**	**1 564**	**4 052**	**2 408**	**3 269**	**22 117**	**39 017**
Expenditure as a % of approved budget	62%	76%	261%	145%	83%	99%	116%	105%
Expenditure as a % of funds available	95%	104%	95%	100%	99%	102%	97%	98%
Staff expenditure by major office	7%	7%	3%	11%	7%	7%	57%	100%

SECTION 2. FINANCIAL REPORT AND AUDITED FINANCIAL STATEMENTS

Certification of the financial statements for the year ended 31 December 2015

In accordance with Article 34 of the Constitution and Financial Regulation XIII of the World Health Organization, attached are the Financial Statements for the year ended 31 December 2015. For the fourth year, the financial statements, accounting policies and notes to the financial statements have been prepared in compliance with International Public Sector Accounting Standards (IPSAS). The Financial Statements are also prepared according to the Financial Regulations of the World Health Organization and its Financial Rules. The Financial Statements and notes have been audited by the Organization's External Auditor, the Republic of the Philippines Commission on Audit, whose opinion is included in this report.

Although the Organization has adopted an annual financial reporting period as stipulated in the revised Financial Regulation XIII,[1] the budgetary period remains a biennium (Financial Regulation II). Therefore, for the purposes of making comparisons between the actual expenses and the planned budget, the biennium's budget is set against two years of annual expenses. The Statement of Comparison of Budget and Actual Amounts (Statement V) provides this comparison by category.

In addition to the General Fund (the programme budget), two other fund groups are included in WHO's financial statements: Member States – other and the Fiduciary Fund. Details of the revenue and expenses for each of these three main fund groups can be found in Schedule I of the report.

In 2015, the Organization provided services to six other entities: The Trust Fund for the Joint United Nations Programme on HIV/AIDS (UNAIDS), the International Drug Purchase Facility (UNITAID), the International Agency for Research on Cancer (IARC), the International Computing Centre (ICC), the African Programme for Onchocerciasis Control (APOC) and the Staff Health Insurance (SHI). Separate financial statements are prepared for each entity, and these are subject to separate external audits. The funds managed by WHO on behalf of these entities[2] are included within the Statement of Financial Position (Statement I). As of 31 December 2015, APOC has ceased to function. The activities have been taken over by the African Region under the Expanded Special Project for Elimination of Neglected Tropical Diseases (EPSEN).

The financial statements for the year ended 31 December 2015, together with the notes to the statements and supporting Schedules I and II, have been reviewed and approved.

Nicholas R. Jeffreys
Comptroller

Dr Margaret Chan
Director General

Geneva, 22 March 2016

[1] See resolution WHA62.6.
[2] Excludes IARC where funds are not managed by WHO.

Letter of transmittal

Republic of the Philippines
COMMISSION ON AUDIT
Commonwealth Avenue, Quezon City, Philippines

LETTER OF TRANSMITTAL

4 April 2016

Dear Sir/Madam,

I have the honour to present to the Sixty-Ninth World Health Assembly, the External Auditor's report and opinion on the financial statements of the World Health Organization for the financial year ended 31 December 2015.

I record my appreciation to the World Health Assembly for the honor and privilege to serve as External Auditor of WHO.

Yours sincerely,

Michael G. Aguinaldo
Chairperson, Commission on Audit
Republic of the Philippines
External Auditor

The President of the Sixty-Ninth World Health Assembly
World Health Organization
Geneva, Switzerland

Opinion of the External Auditor

Republic of the Philippines
COMMISSION ON AUDIT
Commonwealth Avenue, Quezon City, Philippines

INDEPENDENT AUDITOR'S REPORT

To The World Health Assembly

Report on the financial statements

We have audited the accompanying financial statements of the World Health Organization, which comprise the Statement of Financial Position as at 31 December 2015, and the Statement of Financial Performance, Statement of Changes in Net Assets/Equity, Statement of Cash Flow, Comparison of Budget and Actual Amounts for the year then ended and the Notes to the Financial Statements.

Management's responsibility for the financial statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with the International Public Sector Accounting Standards (IPSAS). This responsibility includes: designing, implementing and maintaining internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error; selecting and applying appropriate accounting policies; and making accounting estimates that are reasonable in the circumstances.

Auditor's responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with the International Standards on Auditing issued by the International Auditing and Assurance Standards Board. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation

and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

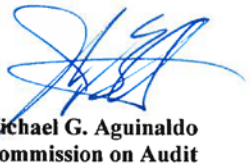
Opinion

In our opinion, these financial statements present fairly, in all material respects, the financial position of the World Health Organization as at 31 December 2015, and its financial performance, changes in net assets/equity, cash flow, and the comparison of budget and actual amounts, in accordance with IPSAS.

Report on other legal and regulatory requirements

Further, in our opinion, the transactions of the World Health Organization that have come to our notice or which we have tested as part of our audit have, in all significant respects, been in accordance with the WHO Financial Regulations.

In accordance with Regulation XIV of the Financial Regulations, we have also issued a Long-form Report on our audit of the World Health Organization.



Michael G. Aguinaldo
Chairperson, Commission on Audit
Republic of the Philippines
External Auditor

Quezon City, Philippines
4 April 2016

Financial statements

World Health Organization

Statement I. Statement of Financial Position

As at 31 December 2015
(In thousands of US dollars)

Description	Notes	31 December 2015	31 December 2014
ASSETS			
Current assets			
Cash and cash equivalents	4.1	431 318	632 891
Short-term investments	4.2	2 754 259	2 823 227
Receivables – current	4.3	866 016	833 240
Staff receivables	4.4	10 702	10 446
Inventories	4.5	53 152	50 417
Prepayments and deposits	4.6	12 474	383
Total current assets		4 127 921	4 350 604
Non-current assets			
Receivables - non-current	4.3	197 472	282 289
Long-term investments	4.2	93 900	70 845
Property, plant and equipment	4.7	65 124	63 993
Intangibles	4.8	2 806	2 802
Total non-current assets		359 302	419 929
TOTAL ASSETS		4 487 223	4 770 533
LIABILITIES			
Current liabilities			
Contributions received in advance	4.9	57 079	61 707
Accounts payable	4.10	53 597	31 579
Staff payable	4.11	2 156	1 777
Accrued staff benefits - current	4.12	46 722	55 823
Deferred revenue	4.13	339 418	366 843
Financial liabilities	4.2	53 177	33 351
Other current liabilities	4.14	108 747	42 717
Inter-entity liabilities	4.15	1 008 911	1 087 558
Total current liabilities		1 669 807	1 681 355
Non-current liabilities			
Long-term borrowings	4.16	27 477	21 671
Accrued staff benefits - non-current	4.12	987 549	937 706
Deferred revenue - non-current	4.13	197 472	282 289
Total non-current liabilities		1 212 498	1 241 666
TOTAL LIABILITIES		2 882 305	2 923 021
NET ASSETS/EQUITY			
Regular budget		43 176	75 344
Voluntary funds		2 166 155	2 353 797
Member States - other		(647 287)	(667 484)
Fiduciary funds		42 874	85 855
TOTAL NET ASSETS/EQUITY		1 604 918	1 847 512
TOTAL LIABILITIES AND NET ASSETS/EQUITY		4 487 223	4 770 533

The section on significant accounting policies and the accompanying notes form part of the financial statements.

World Health Organization

Statement II. Statement of Financial Performance

For the year ended 31 December 2015
(In thousands of US dollars)

Description	Notes	31 December 2015	31 December 2014
REVENUE	5.1		
Assessed contributions		462 651	491 866
Voluntary contributions		1 838 443	2 051 911
Voluntary contributions in-kind and in-service		129 913	50 271
Reimbursable procurement		26 170	12 944
Other revenue		17 965	15 628
Total revenue		2 475 142	2 622 620
EXPENSES	5.2		
Staff costs		920 191	867 460
Medical supplies and materials		265 481	225 296
Contractual services		744 096	565 865
Transfers and grants		311 717	258 537
Travel		233 539	193 681
General operating expenses		193 271	155 672
Equipment, vehicles and furniture		67 716	47 825
Depreciation and amortization		2 433	2 104
Total expenses		2 738 444	2 316 440
Finance revenue	5.3	20 708	6 612
TOTAL (DEFICIT)/SURPLUS FOR THE YEAR		(242 594)	312 792

The section on significant accounting policies and the accompanying notes form part of the financial statements.

World Health Organization

Statement III. Statement of Changes in Net Assets/Equity

For the year ended 31 December 2015
(In thousands of US dollars)

Description	Notes	31 December 2015	Surplus/(deficit)	31 December 2014
General Fund				
Regular budget	6.1	43 176	(32 168)	75 344
Voluntary funds				
Voluntary Contributions Core Fund		154 376	(102 569)	256 945
Voluntary Contributions Specified Fund		1 118 132	(45 790)	1 163 922
TDR Trust Fund		20 890	(10 696)	31 586
HRP Trust Fund		40 146	190	39 956
Special Programmes and Collaborative Arrangements Fund		334 162	(9 611)	343 773
Special Account for Servicing Costs Fund	6.2	302 775	38 328	264 447
Outbreak and Crisis Response Fund		181 409	(71 759)	253 168
Contingency Fund for Emergencies	6.3	14 265	14 265	
Total voluntary funds		2 166 155	(187 642)	2 353 797
Total General Fund		2 209 331	(219 810)	2 429 141
Member States – other				
Common Fund		103 014	18 416	84 598
Enterprise Fund	6.4	9 365	1 262	8 103
Special Purpose Fund	6.5	(759 666)	519	(760 185)
Total Member States – other		(647 287)	20 197	(667 484)
Fiduciary Fund	6.6	42 874	(42 981)	85 855
TOTAL NET ASSETS/EQUITY		1 604 918	(242 594)	1 847 512

The section on significant accounting policies and the accompanying notes form part of the financial statements.

World Health Organization

Statement IV. Statement of Cash Flow

For the year ended 31 December 2015
(In thousands of US dollars)

Description	31 December 2015	31 December 2014
CASH FLOWS FROM OPERATING ACTIVITIES		
TOTAL (DEFICIT) / SURPLUS FOR THE YEAR	(242 594)	312 791
Depreciation and amortization	2 433	2 104
Unrealized (gains)/losses on investments	1 003	29 507
Unrealized (gains)/losses on revaluation of long-term borrowings	525	2 463
(Increase)/decrease in accounts receivable – current	(32 776)	(97 716)
(Increase)/decrease in staff receivables	(256)	903
(Increase)/decrease in inventories	(2 735)	707
(Increase)/decrease in prepayments	(12 091)	3 072
(Increase)/decrease in accounts receivable – non-current	84 817	64 223
Increase/(decrease) in contributions received in advance	(4 628)	(18 385)
Increase/(decrease) in accounts payable	22 018	1 859
Increase/(decrease) in staff payable	379	(548)
Increase/(decrease) in accrued staff benefits – current	(9 101)	(14 326)
Increase/(decrease) in deferred revenue	(27 425)	24 428
Increase/(decrease) in other current liabilities	66 030	(16 754)
Increase/(decrease) in inter-entity liabilities	(78 647)	105 857
Increase/(decrease) in accrued staff benefits – non-current	49 843	(1 411)
Increase/(decrease) in deferred revenue – non-current	(84 817)	(64 223)
Net cash flows from operating activities	(268 022)	334 551
CASH FLOWS FROM INVESTING ACTIVITIES		
(Increase)/decrease in short-term investments	59 071	(419 313)
(Increase)/decrease in long-term investments	(22 616)	13 168
Increase/(decrease) in financial liabilities	28 281	(2 557)
(Increase)/decrease in property, plant and equipment	(3 241)	(4 379)
(Increase)/decrease in intangibles	(327)	(2 825)
Net cash flows from investing activities	61 168	(415 906)
CASH FLOWS FROM FINANCING ACTIVITIES		
Increase/(decrease) in long-term borrowings	5 281	(606)
Net cash flows from financing activities	5 281	(606)
Net increase/(decrease) in cash and cash equivalents	(201 573)	(81 950)
Cash and cash equivalents at beginning of the year	632 891	714 841
Cash and cash equivalents at end of the year	431 318	632 891

The section on significant accounting policies and the accompanying notes form part of the financial statements.

World Health Organization

Statement V. Statement of Comparison of Budget and Actual Amounts

For the year ended 31 December 2015
(In thousands of US dollars)

Description	Programme budget 2014–2015	Expenses 2015	Expenses 2014	Total expenses	Difference – Programme budget and expenses	Implementation (%)
Categories						
1 Communicable diseases	840 800	390 503	326 666	717 169	123 631	85%
2 Noncommunicable diseases	317 900	131 240	106 357	237 597	80 303	75%
3 Promoting health through the life course	388 500	187 827	151 857	339 684	48 816	87%
4 Health systems	531 100	252 939	215 178	468 117	62 983	88%
5 Preparedness, surveillance and response	287 000	144 268	121 459	265 727	21 273	93%
6 Corporate services/enabling functions	684 000	353 292	279 682	632 974	51 026	93%
Emergencies	927 900	1 006 608	689 555	1 696 163	(768 263)	183%
Total	3 977 200	2 466 677	1 890 754	4 357 431	(380 231)	110%
Basis differences						
Tax Equalization Fund expenses		11 862	9 595	21 457		
Special arrangements		84 114	31 935	116 049		
Transfer to IT Fund			812	812		
Other non-programme budget utilization		(24 397)	8 683	(15 714)		
Total basis differences		71 579	51 025	122 604		
Timing differences						
Programme budget expenses for prior periods			180 737	180 737		
Total timing differences			180 737	180 737		
Total expenses – General Fund		2 538 256	2 122 516	4 660 772		
Entity differences						
Expenses under Common Fund, Enterprise Fund, Special Purpose Fund, and Fiduciary Fund		74 023	144 734	218 757		
In-kind/in-service expenses		126 165	49 190	175 355		
Total entity differences		200 188	193 924	394 112		
Total expenses as per the Statement of Financial Performance (Statement II)		2 738 444	2 316 440	5 054 884		

The section on significant accounting policies and the accompanying notes form part of the financial statements.

Notes to the financial statements

1. Basis of preparation and presentation

The financial statements of the World Health Organization have been prepared in accordance with the International Public Sector Accounting Standards (IPSAS). They have been prepared using the historical cost convention. Investments and loans, however, are recorded at fair value or amortized cost. Where a specific matter is not covered by IPSAS, the appropriate International Financial Reporting Standards (IFRS) have been applied.

These financial statements have been prepared under the assumption that WHO is a going concern, and will meet its mandate for the foreseeable future (IPSAS 1-Presentation of Financial Statements).

These financial statements are presented in United States dollars and all values are rounded to the nearest thousands, also denoted as US$ thousands (US$000's).

Functional currency and translation of foreign currencies

Foreign currency transactions are translated into United States dollars at the prevailing United Nations Operational Rates of Exchange, which approximates to the exchange rates at the date of the transactions. The Operational Rates of Exchange are set once a month, and revised mid-month if there are significant exchange rate fluctuations relating to individual currencies.

Assets and liabilities in currencies other than United States dollars are translated into United States dollars at the prevailing United Nations Operational Rates of Exchange year-end closing rate. The resulting gains or losses are accounted for in the Statement of Financial Performance.

The non-United States dollar denominated assets and liabilities in the investment portfolios are translated into United States dollars at the month-end closing rate used by the custodian.

Materiality and the use of judgments and estimates

Materiality[1] is central to WHO's financial statements. The Organization's process for reviewing accounting materiality provides a systematic approach to the identification, analysis, evaluation, endorsement and periodic review of decisions taken involving the materiality of information, spanning a number of accounting areas. The financial statements include amounts based on judgments, estimates and assumptions by management. Changes in estimates are reflected in the period in which they become known.

Financial statements

In accordance with IPSAS 1, a complete set of financial statements has been prepared as follows:

- Statement of Financial Position;
- Statement of Financial Performance;
- Statement of Changes in Net Assets/Equity;
- Statement of Cash Flow;
- Statement of Comparison of Budget and Actual Amounts; and
- Notes to the financial statements, comprising a description of the basis of preparation and presentation of the statements, a summary of significant accounting policies, and other relevant information.

[1] Omissions or misstatements of items are material if they could, individually or collectively, influence the decisions or assessments of users made on the basis of the financial statements.

2. Significant accounting policies

2.1 Cash and cash equivalents

Cash and cash equivalents are held at nominal value and comprise cash on hand, cash at banks, collateral deposits, commercial paper, money market funds and short-term bills and notes. All investments that have a maturity of three months or less from the date of acquisition are included as cash and cash equivalents. This includes cash and cash equivalents held in the portfolios managed by external investment managers.

2.2 Investments and financial instruments

Financial instruments are recognized when WHO becomes a party to the contractual provisions of the instrument until such time as the rights to receive cash flows from those assets have expired or have been transferred and the Organization has transferred substantially all the risks and rewards of ownership. Investments can be classified as being: (i) financial assets or financial liabilities at fair value through surplus or deficit; (ii) held-to-maturity; (iii) available-for-sale; or (iv) bank deposits and other receivables. All purchases and sales of investments are recognized on the basis of their trade date.

Financial assets or financial liabilities at fair value through surplus or deficit are financial instruments that meet either of the following conditions: (i) they are held-for-trading; or (ii) they are designated by the entity upon initial recognition at fair value through surplus or deficit.

Financial instruments in this category are measured at fair value and any gains or losses arising from changes in the fair value are accounted for through surplus or deficit and included within the Statement of Financial Performance in the period in which they arise. All derivative instruments, such as swaps, currency forward contracts or options are classified as held-for-trading except for designated and effective hedging instruments as defined under IPSAS 29 (Financial Instruments: Recognition and Measurement). Financial assets in the externally managed portfolios designated upon initial recognition as at fair value through surplus or deficit are classified as current assets or non-current assets according to the time horizon of the investment objectives of each portfolio. If the time horizon is less than or equal to one year, they are classified as current assets, and if it is more than one year, they are classified as non-current assets.

Held-to-maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity dates that WHO has both the intention and the ability to hold to maturity. Held-to-maturity investments are stated at amortized cost using the effective interest rate method, with interest revenue being recognized on an effective yield basis in the Statement of Financial Performance.

Available-for-sale investments are classified as being available-for-sale where WHO has not designated them either as held-for-trading or as held-to-maturity. Available-for-sale items are stated at fair value (including transaction costs that are directly attributable to the acquisition of the financial asset) with value changes recognized in net assets/equity. Impairment charges and interest calculated using the effective interest rate method are recognized in the Statement of Financial Performance. As at 31 December 2015, no available-for-sale financial assets were held by the Organization.

Bank deposits and other receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. Accrued revenue related to interest, dividends and pending cash to be received from investments are included herein. Bank deposits and other receivables are stated at amortized cost calculated using the effective interest rate method, less any impairments. Interest revenue is recognized on the effective interest rate basis, with the exception of short-term receivables for which the recognition of interest would be immaterial.

Other financial liabilities include payables and accruals relating to investments and are recognized initially at fair value and subsequently measured at amortized cost using the effective interest rate method, with the exception of short-term liabilities for which the recognition of interest would be immaterial.

2.3 Accounts receivable

Accounts receivable are non-derivative financial assets with fixed or determinable payments that are not traded in an active market. Current receivables are for amounts due within 12 months of the reporting date,

while non-current receivables are those that are due more than 12 months from the reporting date of the financial statements.

Voluntary accounts receivable are recognized based on the payment terms specified in a binding agreement between WHO and the contributor. Where no payment terms are specified, the full amount receivable is recognized as currently due. Assessed accounts receivable are recognized annually, at the beginning of the year as per the assessments approved by the Health Assembly. Accounts receivable are recorded at their estimated net realizable value and not discounted, as the effect of discounting is considered immaterial.

An allowance for doubtful accounts receivable is recognized when there is a risk that the receivable may be impaired. Changes in the allowance for doubtful accounts receivable are recognized in the Statement of Financial Performance (Statement II).

2.4 Inventories

WHO recognizes medicines, vaccines, humanitarian supplies, and publications as part of its inventory. Inventories are valued taking the lower amount of (i) cost or (ii) net realizable value, using a weighted average basis. A physical stock count is conducted once annually. Packaging, freight and insurance charges are allocated based on the total value of inventory purchases and added to the inventory value.

Where inventories have been acquired through a non-exchange transaction (i.e. inventories were donated as an in-kind contribution), the value of inventory is determined by reference to the donated goods' fair value at the date of acquisition.

When inventories are sold, exchanged or distributed, their carrying amount is recognized as an expense.

2.5 Prepayments and deposits

Prepayments relate to amounts paid to suppliers for goods or services not yet received. Deposits relate to amounts paid as security for the leasing of office space. Deposits and prepayments are recorded at cost.

2.6 Property, plant and equipment

Property, plant and equipment with a value greater than US$ 5000 are recognized as non-current assets in the Statement of Financial Position (Statement I). Property, plant and equipment are stated at historical cost, less accumulated depreciation and any impairment losses. Property, plant and equipment acquired through a non-exchange transaction are recognized at fair value at the date of acquisition. WHO considers all assets of this type to be non-cash generating.

Depreciation is calculated on a straight-line basis over the asset's useful life except for land, which is not subject to depreciation. Property, plant and equipment are reviewed annually for impairment to ensure that the carrying amount is still considered to be recoverable. The estimated useful lives of the asset classes that make up property, plant and equipment are provided in the table below.

Asset class	Estimated useful life (in years)
Land	n/a
Buildings – permanent	60
Buildings – mobile	5
Furniture, fixtures and fittings	5
Vehicles and transport	5
Office equipment	3
Communications equipment	3
Audiovisual equipment	3
Computer equipment	3
Network equipment	3
Security equipment	3
Other equipment	3

Improvements are capitalized over the remaining life of the asset when the improvement results in an increase in the useful life of the asset. The residual value of the asset and the cost of the improvement will be amortized over the adjusted useful life (remaining life). Normal repair and maintenance costs are expensed in the year where the costs are incurred.

A transitional provision, which will continue until 31 December 2016, has been applied for the initial recognition of property, plant and equipment that were purchased or donated before 1 January 2012. Land and building assets were recognized by location from 1 January 2012 to 31 December 2015.

As allowed under the transitional provision, property, plant and equipment acquired during 2015 other than land and building assets were expensed at the date of purchase and have not been recognized as assets in 2015.

2.7 Intangibles

Intangible assets that are above the pre-established threshold of US$ 100 000 are stated at historical cost less accumulated amortization and any impairment losses. Amortization is determined over the estimated useful life of the assets using the straight-line method of amortization. The estimated useful life of "software acquired externally" is six years.

WHO's intangible assets are assumed to have a residual value of zero as intangible assets are not sold or transferred at the end of their useful life. Intangible assets are reviewed annually for impairment. Some intangible assets may have a shorter useful life.

2.8 Leases

A lease is an agreement whereby the lessor conveys to the lessee (the Organization), in return for a payment or series of payments, the right to use an asset for an agreed period of time. Every lease is reviewed to determine whether it constitutes a financial or operating lease. Necessary accounting entries and disclosures are made accordingly.

Where WHO is the lessor, lease revenue from operating leases is recognized as revenue on a straight-line basis over the lease term. All costs associated with the asset incurred in earning the lease revenue, including depreciation, are recognized as an expense.

2.9 Contributions received in advance

Contributions received in advance arise from legally binding agreements between WHO and its contributors – including governments, international organizations and private and public institutions – whereby contributions are received in advance of the amounts concerned falling due to the Organization.

2.10 Accounts payable and accrued liabilities

Accounts payable are financial liabilities for goods or services that have been received by WHO and invoiced but not yet paid for.

Accrued liabilities are financial liabilities for goods or services that have been received by WHO and which have neither been paid for nor invoiced to WHO.

Accounts payable and accrued liabilities are recognized at cost, as the effect of discounting is considered immaterial.

2.11 Employee benefits

WHO recognizes the following categories of employee benefits:

- short-term employee benefits that fall due wholly within 12 months following the end of the accounting period in which employees render the related service;
- post-employment benefits;
- other long-term employee benefits;
- termination benefits.

WHO is a member organization participating in the United Nations Joint Staff Pension Fund (UNJSPF), which was established by the United Nations General Assembly to provide retirement, death, disability and related benefits to employees. The Pension Fund is a funded, multi-employer defined benefit plan. As specified by Article 3(b) of the Regulations of the Fund, membership in the Fund shall be open to the specialized agencies and to any other international, intergovernmental organization that participates in the common system of salaries, allowances and other conditions of service of the United Nations and the specialized agencies.

The plan exposes participating organizations to actuarial risks associated with the current and former employees of other organizations participating in the Pension Fund, with the result that there is no consistent and reliable basis for allocating the obligation, plan assets, and costs to individual organizations participating in the plan. WHO and the UNJSPF are not in a position to identify WHO's proportionate share of the defined benefit obligation, the plan assets and the costs associated with the plan with sufficient reliability for accounting purposes; this is also true for other organizations participating in the Pension Fund. WHO has therefore treated it as a defined contribution plan in line with the requirements of IPSAS 25 (Employee Benefits). WHO's contributions to the plan during the financial period are recognized as expenses in the Statement of Financial Performance (Statement II).

2.12 Provisions and contingent liabilities

Provisions are recognized for future liabilities and charges where WHO has a present legal or constructive obligation as a result of past events and it is probable that the Organization will be required to settle the obligation.

Other commitments, which do not meet the recognition criteria for liabilities, are disclosed in the notes to the financial statements, as contingent liabilities when their existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events that are not wholly within the control of WHO.

2.13 Contingent assets

Contingent assets will be disclosed when an event gives rise to a probable inflow of economic benefits or service potential and there is sufficient information to assess the probability of the inflow of economic benefits or service potential.

2.14 Deferred revenue

Deferred revenue derives from legally binding agreements between WHO and its contributors, including governments, international organizations, and private and public institutions. Deferred revenue is recognized when:

- a contractual agreement is confirmed in writing by both the Organization and the contributor; and
- the funds are earmarked and due in a future period.

Deferred revenue also includes advances from exchange transactions.

Deferred revenue is presented as non-current if the revenue is due one year or more after the reporting date.

2.15 Revenue

Revenue comprises gross inflows of economic benefits or service potential received and receivable by WHO during the year, and represents an increase in net assets/equity. The Organization recognizes revenue following the established criteria of IPSAS 9 (Revenue from Exchange Transactions) and IPSAS 23 (Revenue from Non-Exchange Transactions).

The main sources of revenue for WHO include but are not limited to:

Non-exchange revenue

- **Assessed contributions.** Revenue from contributions from Member States and Associate Members is recorded annually at the beginning of the year as per the assessments approved by the Health Assembly.
- **Voluntary contributions.** Revenue from voluntary contributions is recorded when a binding agreement is signed by WHO and the contributor. Where there are "subject to" clauses in an agreement, WHO does not control the resource and does not record the revenue and amount receivable until the cash is received. Where there are no payment terms specified by the contributor or payment terms are in the current accounting year, revenue is recognized in the current period. Where payment terms specify payment after the year end, the amount is reported as deferred revenue. Where the start date of the contract is after 31 December, revenue is recognized in the future accounting year.
- **Contributions in-kind and in-service.** Contributions in-kind and in-service are recorded by WHO at an amount equal to their fair market value as determined at the time of acquisition, based on an agreement between WHO and the contributor and upon confirmation from the receiving budget centre of the receipt of the goods or services. An entry corresponding to the expense is recorded in the same period that the contributions in-kind and in-service are recorded as revenue.

Exchange revenue

- **Reimbursable procurement, concessions, and revolving sales.** Revenue from reimbursable procurement on behalf of Member States or from the sale of goods or services is recorded on an accrual basis at the fair value of the consideration received or receivable when it is probable that the future economic benefits and/or service potential will flow to WHO and those benefits can be measured reliably. The corresponding expense is recognized in the same year as the revenue.

2.16 Expenses

Expenses are defined as decreases in economic benefits or service potential during the reporting period in the form of outflows, consumption of assets, or incurrences of liabilities that result in decreases in net assets/equity. WHO recognizes expenses at the point where goods have been received or services rendered (delivery principle) and not when cash or its equivalent is paid.

2.17 Fund accounting

Fund accounting is a method of segregating resources into categories (i.e. funds) to identify both the source and the use of the funds. Establishing such funds helps to ensure better reporting of revenue and expenses. The General Fund, the Member States - Other and the Fiduciary Fund serve to ensure the proper segregation of revenue and expenses. Any transfers between funds that would result in duplication of revenue and/or expenses are eliminated during consolidation. Intra-fund transfers such as programme support costs within the General Fund, are also eliminated.

General Fund

The accounts contained under this fund support the implementation of the programme budget. The General Fund contains the following:

- **Assessed Contributions Fund.** This fund consolidates revenues and expenses arising from assessed contributions from Member States and includes interest and other miscellaneous income.

- **Tax Equalization Fund.** In accordance with resolution WHA21.10, in which the Health Assembly decided to establish the Tax Equalization Fund, the assessed contributions of all Member States are reduced by the revenue generated by the staff assessment plan. In determining the reduction of assessed contributions to be applied to the Member States concerned, the Tax Equalization Fund is credited with the revenue from the staff assessment plan, the credits being recorded in the name of individual Member States, in proportion to their assessments for the biennium. For those Member States that levy income tax on emoluments received from the Organization by their nationals or others liable to such taxes, the credit from the staff assessment plan is charged with the estimated amount to be levied by those Member States. Those amounts which have been charged are, in turn, used by the Organization to reimburse income tax paid by the staff concerned, as per resolution WHA21.10.

- **Working Capital Fund.** The Fund was established to implement the programme budget pending receipt of assessed contributions in arrears. In accordance with Financial Regulation VII, implementation of that part of the budget financed from assessed contributions may be financed from the Working Capital Fund and thereafter by internal borrowing against available cash reserves of WHO, excluding trust funds. Amounts borrowed are repaid from the collection of arrears of assessed contributions and are credited first against any internal borrowing and then against any borrowing from the Working Capital Fund.

- **Voluntary funds (core, specified and partnerships).** This fund consolidates revenue and expenses arising from voluntary contributions and includes the special account for servicing costs.

Member States – other

The following accounts are contained in Member States – other:

- **Common Fund.** This fund reflects the movement in the asset and liability accounts of the Organization resulting from changes in items such as inventory, depreciation and unrealized exchange gains and losses.

- **Enterprise Fund.** This fund contains accounts that generate self-sustaining revenue. The revenue and expenses under this fund are not included in the reporting of the programme budget. The Enterprise Fund contains the following accounts:

  - Revolving Sales Fund[1]
  - Concessions Fund
  - Insurance Policies Fund
  - Garage Rental Fund
  - Reimbursable Procurement Fund[2]
  - In-kind Contributions Fund[3]

[1] In accordance with resolution WHA22.8 and resolution WHA55.9, the Revolving Sales Fund is credited with proceeds from the sale of publications, international certificates of vaccination, films, videos, DVDs and other information material. The related costs of production and printing are charged to the Fund.

[2] Transactions under this fund are from exchange transactions. Total revenue equals total expenses; hence there is no fund balance at year-end.

[3] Transactions under this fund are from non-exchange transactions. Total revenue equals total expenses; hence there is no fund balance at year-end.

- **Special Purpose Fund.** The accounts contained under this fund represent transfers from the General Fund or appropriations by the Health Assembly. The revenue and expenses under this fund are not included in the reporting of the programme budget. The Special Purpose Fund contains the following accounts:

  - Real Estate Fund
  - Building Loan Fund (refer to Notes 6.7 and 4.16)
  - Security Fund
  - Information Technology Fund
  - Special Fund for Compensation
  - Terminal Payments Fund
  - Non-Payroll Staff Entitlements Fund
  - Post Occupancy Charge Fund
  - Internal Service Cost Recovery Fund
  - Staff Health Insurance Fund
  - Stockpiles Replenishment Fund
  - Polio Staff Fund

Fiduciary Fund

This fund accounts for assets that are held by WHO in a trustee or agent capacity for others and that cannot be used to support the Organization's own programmes. The Fund includes the assets of the partnerships that are administered by the Organization and whose budgets are not approved by the Health Assembly. Similarly, financial activities related to the financing of WHO's long-term liabilities are managed through it. The Fund is not available for operations and does not contribute to the Programme budget 2014–2015, and contains the following accounts:

- WHO Framework Convention on Tobacco Control (FCTC)
- Stop TB Partnership Fund (refer to Note 6.7)
- Stop TB Partnership Global Drug Facility Fund (refer to Note 6.7)
- Roll Back Malaria Partnership Fund[1]
- Partnership for Maternal, Newborn and Child Health Fund
- United Nations System Standing Committee on Nutrition Fund
- Alliance for Health Policy and System Research Fund
- Global Health Workforce Alliance Fund
- European Observatory on health systems and policies
- Expanded Special Project for Elimination of Neglected Tropical Diseases (ESPEN) Fund (refer to Note 6.7)

[1] Roll Back Malaria partnership fund operations were closed at 31 December 2015. Administrative closure of the fund will be completed in 2016.

2.18 Segment reporting

As required under IPSAS, WHO reports on segments based on its regional structure. Revenue, expenses, assets and liabilities are reported for each major office (region). The use of major offices is in line with the decision-making practices of the Member States and the Secretariat, with respect to the allocation of resources. WHO's programme budget is presented by major office, which supports using major offices as the segments. Furthermore, the accountability for results and management of assets and liabilities lies with the respective Regional Director.

2.19 Statement of Cash Flow

The Statement of Cash Flow (Statement IV) is prepared using the indirect method.

2.20 Budget comparison

WHO's budget and accounting bases differ. Budgets within the Organization are approved on a modified cash basis rather than the full accrual basis of IPSAS. In addition, budgets are prepared on a biennial basis.

WHO's financial statement covers all the activities of the Organization, however, budgets are approved only for the General Fund. There are no approved budgets for other funds. All funds are administered in accordance with the Financial Regulations and Financial Rules.

As required under IPSAS 24 (Presentation of Budget Information in Financial Statements), the actual amounts presented on a comparable basis to the budget shall, where the financial statements and the budget are not prepared on a comparable basis, be reconciled to the actual amounts presented in the financial statements, identifying separately any basis, timing, presentation and entity differences. There may also be differences in formats and classification schemes adopted for the presentation of financial statements and the budget.

The Health Assembly approved the Programme budget 2014–2015[1]. Statement of Comparison of Budget and Actual Amounts (Statement V) compares the final budget to actual amounts calculated on the same basis as the corresponding budgetary amounts. As the bases used to prepare the budget and financial statements differ, Note 7 reconciles the actual amounts presented in Statement V with the actual amounts presented in Statement of Cash Flow (Statement IV).

2.21 Consolidated and non-consolidated entities

Non-consolidated entities

WHO provides administrative services to a number of entities, each of which produces a full set of financial statements that are subject to a separate audit. The following six entities have their own governing bodies and are not governed by the World Health Assembly:

- Trust Fund for the Joint United Nations Programme on HIV/AIDS (UNAIDS)
- International Drug Purchase Facility (UNITAID)
- International Agency for Research on Cancer (IARC)
- International Computing Centre (ICC)
- African Programme for Onchocerciasis Control (APOC)[2]
- Staff Health Insurance (SHI)

[1] See resolution WHA 66.2.

[2] APOC operations were closed at 31 December 2015.

3. Note on the restatement of balances

The financial statements are rounded to thousands of US dollars. Comparative figures have been adjusted; as a result, rounding differences have occurred. Rounding differences are adjusted against finance revenue under Statement II (refer to Note 5.3), Common Fund under “Member States – Other” in Statements I and III and other non-programme budget utilization under “Basis differences” in Statement V.

4. Supporting information to the Statement of Financial Position

4.1 Cash and cash equivalents

Cash and cash equivalents comprise cash on hand, cash at banks, investments in money market funds, collateral deposits, bank deposits, and short-term highly liquid investments with original maturity dates of three months or less from the date of acquisition.

Cash and cash equivalents are held for the purpose of meeting the short-term cash requirements of the Organization, rather than for longer-term investment purposes. They are held on behalf of the Organization, including the General Fund, the Special Purpose Fund, the Enterprise Fund, the Fiduciary Fund and non-WHO entities administered by the Organization. The figures include cash and cash equivalents held in the portfolios managed by external investment managers. The table below shows cash and cash equivalents by major office.

Description	31 December 2015	31 December 2014
	US$ thousands	
Major office		
Headquarters	138 587	176 926
Regional Office for Africa	24 515	24 351
Regional Office for the Eastern Mediterranean	11 837	8 068
Regional Office for Europe	1 516	737
Regional Office for South-East Asia	2 401	3 433
Regional Office for the Western Pacific	3 660	4 204
Cash at banks, investment accounts, in transit and on hand	**182 516**	**217 719**
Headquarters	248 802	415 172
Cash and cash equivalents held by investment portfolios	**248 802**	**415 172**
Total cash and cash equivalents	**431 318**	**632 891**

4.2 Investments and financial instruments

Details of the accounting policies for investments and financial instruments are described in Note 2.2.

WHO's principal investment objectives in descending order of priority are:

- the preservation of capital;
- the maintenance of sufficient liquidity to meet the payment of liabilities on time; and
- the optimization of investment returns.

The Organization's investment policy reflects the nature of its funds, which may be held either short-term pending implementation of programmes, or for a longer term to meet its long-term liabilities.

WHO's investments include funds managed for other entities.

An analysis of the investments of the Organization is provided in the following table.

Investments and financial instruments (in US$ thousands)

Description	Internally managed funds				Externally managed funds					Foreign Exchange Hedging contracts	Grand total 31 December 2015	Grand total 31 December 2014
	Time Deposits	Held-to-Maturity	Long term portfolio	Total	Short term portfolio A	Short term portfolio B	Short term portfolio C	Short term portfolio D	Total			
Investments under current Assets												
Cash and cash equivalent held by investment portfolio	200 059		1	200 060	6 307	16 422	25 470	543	48 742		248 802	415 172
Short-term investments												
Financial assets at fair value through surplus or deficit - held-for-trading					1 122	222		1 159	2 503	1 442	3 945	5 477
Financial assets at fair value through surplus or deficit - upon initial recognition					417 140	287 361	523 037	532 586	1 760 124		1 760 124	1 428 824
Financial assets at amortized cost												55 015
Bank deposits & other receivables	978 392		41	978 433	4 769	4 247	1 391	1 350	11 757		990 190	1 333 911
Total short-term investments	978 392		41	978 433	423 031	291 830	524 428	535 095	1 774 384	1 442	2 754 259	2 823 227
Total investments under current assets	1 178 451		42	1 178 493	429 338	308 252	549 898	535 638	1 823 126	1 442	3 003 061	3 238 399
Investments under non-current assets												
Long-term Investments												
Financial assets at fair value through surplus or deficit - upon initial recognition			93 900	93 900							93 900	70 845
Financial assets at amortized cost												
Total long-term assets			93 900	93 900							93 900	70 845
Total investments under non-current assets			93 900	93 900							93 900	70 845
Financial Liabilities under current liabilities												
Financial liabilities at fair value through surplus or deficit held-for-trading					(2 537)			(367)	(2 904)	(10 200)	(13 104)	(20 157)
Payables and accruals					(34 580)	(5 493)			(40 073)		(40 073)	(13 194)
Total financial liabilities					(37 117)	(5 493)		(367)	(42 977)	(10 200)	(53 177)	(33 351)
Total financial liabilities under current liabilities					(37 117)	(5 493)		(367)	(42 977)	(10 200)	(53 177)	(33 351)
Total investment - net	1 178 451		93 942	1 272 393	392 221	302 759	549 898	535 271	1 780 149	(8 758)	3 043 784	3 275 893

Short-term investments

Short-term investments relating to funds held pending the implementation of programmes are invested in cash and high-quality short-term government, agency, corporate bonds and time deposits as defined in the approved investment policy. Investments included within "financial assets at fair value through surplus or deficit" include fixed-income securities and derivative instruments held to cover projected liabilities and any unexpected cash requirements. Financial assets in the externally managed portfolios designated upon initial recognition as at fair value through surplus or deficit are classified as short-term investments where the investment time horizon objective of these portfolios is less than or equal to one year. For short-term tactical investment reasons, the external managers of these portfolios may from time to time decide to lengthen temporarily the average duration of these portfolios to slightly longer than one year. This will not change the short-term classification of these financial assets unless the investment time horizon objective of the portfolio and the duration of its benchmark have been changed to more than one year. The investments in the "held-to-maturity" portfolio with a duration of less than one year are classified as current assets in the category "financial assets at amortized cost". At the end of 2015, there were no investments in the held-to-maturity portfolio. Other receivables include accrued revenue on investments and receivables from investments that were sold before 31 December 2015 and settled after that date.

Description	31 December 2015	31 December 2014
	US$ thousands	
Financial assets at fair value through surplus or deficit – held-for-trading	3 945	5 476
Financial assets at fair value through surplus or deficit – upon initial recognition	1 760 124	1 428 824
Financial assets at amortized cost	-	55 015
Bank deposits and other receivables	990 190	1 333 912
Total short-term investments	**2 754 259**	**2 823 227**

Long-term investments

Long-term investments for the Terminal Payments Fund are placed in line with the approved investment policy and are invested in high-quality, medium-dated and long-dated government, agency and corporate bonds. The financial assets at fair value through surplus or deficit upon initial recognition in the Terminal Payments Fund investment portfolio are classified as long-term investments in accordance with the investment time horizon objective of the portfolio and the duration of its benchmark, which are both greater than one year.

Description	31 December 2015	31 December 2014
	US$ thousands	
Financial assets at fair value through surplus or deficit – upon initial recognition	93 900	70 845
Total long-term investments	**93 900**	**70 845**

Financial liabilities

Financial liabilities disclosed under "financial liabilities at fair value through surplus or deficit – held-for-trading" include derivative transactions, such as foreign exchange forward contracts and interest rate swaps. Financial liabilities disclosed under "payables and accruals" relate to other financial liabilities from investments, including assets purchased before 31 December 2015 and settled after that date.

Description	31 December 2015	31 December 2014
	US$ thousands	
Financial liabilities at fair value through surplus or deficit – held-for-trading	13 104	20 157
Payables and accruals	40 073	13 194
Total financial liabilities	**53 177**	**33 351**

The fair value hierarchy

The fair value hierarchy represents the categorization of market pricing to indicate the relative ease with which the value of investments held by WHO can be realized.

The majority of the financial instruments held by WHO have quoted prices in active markets which are classified as Level 1. Derivative instruments that are "over the counter" are classified as Level 2 because their fair value is observable – either directly as a price, or indirectly after being derived from prices. The instruments shown under the Level 2 fair value measurement category consist of foreign currency hedging forward contracts and derivative contracts in the externally managed portfolios.

Description	Level 1	Level 2	Total
	US$ thousands		
Cash and cash equivalents	**4 003**	–	**4 003**
Short-term investments			
Financial assets at fair value through surplus or deficit – held-for-trading		3 570	3 570
Financial assets at fair value through surplus or deficit – upon initial recognition	1 760 124		1 760 124
Total short-term investments			
Long-term investments	**1 760 124**	**3 570**	**1 763 694**
Financial assets at fair value through surplus or deficit – upon initial recognition	93 900		93 900
Financial liabilities			
Financial liabilities at fair value through surplus or deficit – held-for-trading	(920)	(12 152)	(13 072)
Total	**1 857 107**	**(8 582)**	**1 848 525**

Risk management

WHO is exposed to financial risks including credit risk, interest rate risk, foreign exchange risk and investment price risk. The Organization uses derivative financial instruments to hedge some of its risk exposures. In accordance with WHO's Financial Regulations, funds not required for immediate use may be invested. All investments are carried out within the framework of the investment policy approved by the Director-General. Some portfolios are managed by external managers appointed by the Organization to manage funds in accordance with a defined mandate. The Advisory Investment Committee reviews regularly the investment policies, the investment performance and the investment risk for each investment portfolio. The Committee is composed of external investment specialists who can make investment recommendations to the Director-General.

Nature of financial instruments

Investments are categorized as follows.

Investments with short-term maturities. These investments are invested in cash and high-quality short-dated government, agency, and corporate bonds as defined in the approved investment policy.

Investments with long-term maturities. These investments comprise funds managed for the Terminal Payments Fund as defined in the approved investment policy. They are invested in high-quality medium-dated and long-dated government, agency, corporate bonds and an externally-managed global bond index fund.

Credit risk

The investments of the Organization are widely diversified in order to limit its credit risk exposure to any individual investment counterparty. Investments are placed with a wide range of counterparties using minimum credit quality limits and maximum exposure limits by counterparty established in investment mandates. These limits are applied both to the portfolios managed internally by the Organization's Treasury Unit, and to the portfolios managed by external investment managers. The Treasury Unit monitors the total exposure to counterparties across all internally and externally managed portfolios.

The credit risk and liquidity risk for cash and cash equivalents are minimized by investing only in major financial institutions that have received strong investment grade credit ratings from primary credit rating agencies. The Treasury Unit regularly reviews the credit ratings of the approved financial counterparties and takes prompt action whenever a credit rating is downgraded. The investments with long-term credit ratings are summarized as follows.

Minimum rating category	Total asset value US$ thousands
AAA	291 191
AA+	607 326
AA	106 886
AA-	278 136
A+	101 093
A	121 575
A-	82 279
Not rated	265 540
Total	**1 854 026**

Where the investments and securities are not rated for credit worthiness by the major credit ratings agencies (for example, fixed income securities issued by sovereigns, collateralized mortgage obligations issued by sovereign-backed agencies and investment funds), the Treasury Unit ensures that the deposits and securities and the constituent securities in the investment funds are issued by issuers whose credit ratings are equal to or better than the single A minimum credit rating requirement for WHO investments as set out in the investment guidelines for the external portfolio managers, which are agreed with the Advisory Investment Committee, and the investment grade minimum credit rating requirement for investments for the Terminal Payments Fund, which is also agreed with the Advisory Investment Committee.

Interest rate risk

WHO is exposed to interest rate risk through its short-term and long-term fixed-income investments. The investment duration is a measure of sensitivity to changes in market interest rates. The effective average duration of the Organization's investments as at 31 December 2015 was 0.5 years for the short-term investments and 6.3 years for the long-term investments. The duration of the long-term investments was lengthened by purchasing longer-term fixed income products to better match the duration of the liabilities that are funded by these investments.

Fixed-income derivative instruments may be used by external investment managers to manage interest rate risk under strict investment guidelines. Interest rate instruments of this type are used for portfolio duration management and for strategic interest rate positioning.

Foreign exchange currency risk

WHO receives contributions and makes payments in currencies other than the United States dollar. The Organization is thus exposed to foreign exchange currency risk arising from fluctuations in currency exchange rates. Exchange rate gains and losses on the purchase and sale of currencies, revaluation of cash book balances, and all other exchange differences are adjusted against the funds and accounts eligible to receive interest under the interest apportionment programme. The translation of transactions expressed in other currencies into the United States dollar is performed at the United Nations Operational Rates of Exchange prevailing at the date of transaction. Assets and liabilities that are denominated in foreign currencies are translated at the United Nations Operational Rates of Exchange year-end closing rate. Forward foreign exchange contracts are transacted to hedge foreign currency exposures and to manage short-term cash flows. Realized and unrealized gains and losses resulting from the settlement and revaluation of foreign currency transactions are recognized in the Statement of Financial Performance (Statement II).

With effect from 2014, 50% of assessed contributions are calculated in Swiss francs to reduce the currency risk of headquarters expenses in that currency.[1]

Hedging foreign exchange exposures on future payroll cost: The United States dollar value of non-dollar expenses in 2016 has been protected from the impact of movements in foreign exchange rates through the transaction of forward currency contracts during 2015. As at 31 December 2015, these forward foreign currency exchange hedging contracts by currency are summarized as follows.

Currency forward bought	(in thousands)	Net amount sold (US$ thousands)	Net unrealized gain/(loss) (US$ thousands)
Swiss franc	117 120	123 992	(5 933)
Euro	92 400	103 043	(2 013)
Indian rupee	1 034 400	15 164	20
Malaysian ringgit	36 000	8 979	(650)
Philippine peso	754 800	16 244	(405)
Total		**267 422**	**(8 981)**

There was a net unrealized loss on these contracts of US$ 9 million as at 31 December 2015 (unrealized loss of US$ 18 million as at 31 December 2014). Realized gains or losses on these contracts will be recorded on maturity of the contracts and applied during 2016.

Hedging foreign exchange exposures on receivables and payables: Currency exchange risk arises as a result of differences in the exchange rates at which foreign currency receivables or payables are recorded, and the exchange rates at which the cash receipt or payment is subsequently recorded. A monthly programme of currency hedging is in place to protect against this foreign currency risk. On a monthly basis, the exposures in respect of accounts receivable and accounts payable are netted by currency and each significant net foreign currency exposure is bought or sold forward using a forward foreign exchange contract equal and opposite to the net currency exposure.

These exposures are re-balanced at each month-end to coincide with the setting of the monthly United Nations Operational Rates of Exchange. Through this process, the exchange gains or losses realized on the forward foreign currency contracts match the corresponding unrealized exchange losses and gains on the movements in net accounts receivable and accounts payable. As at 31 December 2015, the total forward foreign currency exchange hedging contracts by currency were as follows.

Currency forward sold	(in thousands)	Currency forward bought (US$ thousands)	Net unrealized gain/(loss) (US$ thousands)
Australian dollar	2 000	1 455	-
Canadian dollar	21 700	15 634	3
Swiss franc	3 200	3 228	29
Euro	83 650	91 483	(154)
Pound sterling	63 800	94 466	(181)
Norwegian kroner	6 300	724	7
New Zealand dollar	2 500	1 716	11
Total		**208 706**	**(285)**

[1] See resolution WHA 66.16.

There was a net unrealized loss on these contracts of US$ 9.3 million as at 31 December 2015 (unrealized net gain of US$ 0.6 million as at 31 December 2014). Realized gains or losses on these contracts will be recorded on the maturity of the contracts and applied during 2016.

Forward foreign exchange contracts to manage operational cash flows: Forward foreign exchange contracts are also used to manage short-term cash flows of foreign currency balances to minimize foreign currency transaction risk. At 31 December 2015 a total net amount of 50.6 million Swiss francs was forward sold against the United States dollar. The maturity dates of these forward foreign exchange contracts were in January 2016. Net unrealized gains on these contracts amounted to US$ 0.5 million as at 31 December 2015 (unrealized net losses of US$ 0.4 million as at 31 December 2014).

Sensitivity of forward foreign exchange contracts to movements in the relative value of the United States dollar: A 1% appreciation in the relative value of the United States dollar against the forward foreign exchange hedging contracts mentioned above would result in an increase in the net unrealized gain of US$ 1.4 million. A 1% depreciation in the relative value of the United States dollar would result in a decrease in the net unrealized gain of US$ 1.4 million.

Forward and spot foreign exchange contracts and other derivative financial instruments are held within the externally managed investment portfolios: In accordance with the investment guidelines set up for each externally managed portfolio, the external investment managers use forward and spot foreign exchange contracts, futures contracts and interest rate swap contracts to manage the currency and interest rate risk of groups of securities within each portfolio. The net values of these instruments as at 31 December 2015, as evaluated by the Organization's investment custodian, are recorded by portfolio under "financial assets/liabilities at fair value – held-for-trading". The outstanding forward and spot foreign exchange contracts are summarized below.

Net sold amount	(in thousands)	US dollar equivalent (in thousands)
Australian dollar	5 202	3 778
Canadian dollar	400	288
Czech krona	181 264	7 373
Danish kroner	92 045	13 399
Euro	29 560	32 128
Japanese yen	481 000	4 001
Pound sterling	56 437	83 184
Mexican peso	41 118	2 369
Total		**146 520**

A 1% appreciation in the relative value of the United States dollar against the above-mentioned forward foreign exchange hedging contracts would result in an increase in the unrealized loss of US$ 0.2 million. A 1% depreciation in the relative value of the United States dollar would result in an increase in the unrealized gain of US$ 0.2 million.

The net outstanding interest rate and bond futures contracts are summarized below.

Long positions

Products	Exchange[a]	No. of contracts
Eurodollar MAR 2016	IMM	6
Eurodollar JUN 2016	IMM	51
Eurodollar MAR 2017	IMM	2
Eurodollar JUN 2017	IMM	7
US 2 year T-Note MAR 2016	CBOT	3
Australian T-Bond 3Y MAR 2016	ASX	451

Short positions

Products	Exchange[a]	No. of contracts
Eurodollar SEP 2016	IMM	(48)
Eurodollar DEC 2016	IMM	(8)
Eurodollar SEP 2017	IMM	(14)
Eurodollar DEC 2017	IMM	(8)
Eurodollar MAR 2018	IMM	(2)
Eurodollar JUN2018	IMM	(3)
Eurodollar SEP 2018	IMM	(204)
Eurodollar DEC 2018	IMM	(2)
Eurodollar SEP 2019	IMM	(10)
Eurodollar Future Call JUN 2016 9875	IMM	(254)
Eurodollar Future Call DEC 2016 9875	IMM	(783)
Eurodollar Future Put DEC 2016 9875	IMM	(783)

a. ASX refers to Australian Securities Exchange. IMM refers to the International Monetary Market and CBOT refers to Chicago Board of Trade. IMM and CBOT are part of Chicago Mercantile Exchange Group.

The outstanding interest rate swap contracts are summarized below.

Currency/Notional amount (in thousands)		US dollar equivalent (in thousands)	Pay/receive	Maturity
US dollar	42 700	42 700	Pay fixed/receive floating	December 2019
Canadian dollar	100 800	72 565	Pay floating/receive fixed	October 2017
Mexican peso	524 400	30 363	Pay floating/receive fixed	December 2017

4.3 Accounts receivable

As at 31 December 2015, total accounts receivable (current and non-current) amounted to US$ 1063 million (US$ 1116 million as at 31 December 2014). The receivable balance includes outstanding amounts for both assessed and voluntary contributions. Accounts receivable are split between current and non-current, based on the payment terms of when the amounts become due.

Description	31 December 2015	31 December 2014
	US$ thousands	
Accounts receivable – current		
Assessed contributions receivable[a]	122 303	77 955
Voluntary contributions receivable[b]	766 328	779 331
Reimbursable procurement receivable	59	116
Revolving sales receivable	194	155
Other receivables	5 573	3 809
Allowance for doubtful accounts receivable	(28 441)	(28 126)
Total accounts receivable – current	**866 016**	**833 240**
Accounts receivable – non-current		
Outstanding rescheduled assessments receivablea	23 039	27 000
Voluntary contributions receivableb	197 472	282 289
Allowance for doubtful accounts receivable	(23 039)	(27 000)
Total accounts receivable – non-current	**197 472**	**282 289**
Total accounts receivable	**1 063 488**	**1 115 529**

a. For details of the status of collection of assessed contributions, see document A69/48

b.Further details of voluntary contributions by fund and by contributor are available on the WHO programme budget web portal and on the WHO website (http://www.who.int/about/finances-accountability/funding/voluntary-contributions/en/).

As at 31 December 2015, the total allowance for doubtful accounts receivable was US$ 51.5 million (US$ 55.1 million at 31 December 2014). This figure comprises an allowance of US$ 48.3 million for assessed contributions and an allowance of US$ 3.2 million for voluntary contributions.

The allowance for assessed contributions receivable includes the following amounts receivable from prior years: all rescheduled amounts receivable and any current amounts receivable from Member States in arrears. The allowance for voluntary contributions receivable is based on a detailed review of all amounts receivable more than one year overdue and a review of amounts less than one year overdue where there is evidence that the amount is unlikely to be received.

With certain contributors, WHO signs agreements that may span many years of implementation. These agreements do not state the payment terms for the transfer of instalments; instead, they are reimbursed based on quarterly expenses incurred. WHO records the full amount of revenue in the financial year in which the agreement is signed and recognizes the full receivable as currently due. As at 31 December 2015, the total receivable shown as currently due under this arrangement was US$ 357.9 million outstanding, of which US$ 66.2 million outstanding was due on agreements ending in 2017 and beyond.

Description	31 December 2015	31 December 2014
	US$ thousands	
Opening balance – assessed contributions	43 453	42 407
Increase in allowance for doubtful accounts receivable	4 848	1 046
Ending balance – assessed contributions	48 301	43 453
Opening balance – voluntary contributions	11 673	11 698
Write off of account receivable previously provided	(9 145)	–
Increase/(decrease) in allowance for doubtful accounts receivable	651	(26)
Ending balance – voluntary contributions	**3 179**	**11 673**
Total allowance for doubtful accounts receivable	**51 480**	**55 126**
Allowance for doubtful accounts receivable		
Allowance – current	28 441	28 126
Allowance – non-current	23 039	27 000
Total allowance for doubtful accounts receivable	**51 480**	**55 126**

4.4 Staff receivables

In accordance with Staff Regulations and Staff Rules, WHO staff members are entitled to certain advances including those for salary, education, rent and travel.

The total balance of staff receivables amounted to US$ 10.7 million as at 31 December 2015 (US$ 10.4 million as at December 2014). The largest balance relates to education grant advances made to staff for the 2015 portion of the 2015–2016 school year.

Description	31 December 2015	31 December 2014
	US$ thousands	
Salary advances	839	780
Education grant advances	7 724	7 607
Rental advances	1 514	1 543
Travel receivables	544	400
Other staff receivables	81	116
Total staff receivables	**10 702**	**10 446**

4.5 Inventories

The total value of inventory as at 31 December 2015 was US$ 53.2 million (US$ 50.4 million as at 31 December 2014).

The movement of inventory items during the year are shown in the table below:

Description	31 December 2014	Net additions	Net shipments	Net disposals and expired items	Net inventory in-transit	31 December 2015
	US$ thousands					
Medicines, vaccines and humanitarian supplies	43 626	64 432	63 140	2 419	4 599	47 098
Publications	6 791	6 270	5 420	1 587		6 054
Total inventory	**50 417**	**70 702**	**68 560**	**4 006**	**4 599**	**53 152**

Total expenses relating to inventories during the period (net shipments, net disposals and expired items) amounted to US$ 72.6 million (US$ 56 million as at 31 December 2014). The expenses relating to inventories

are reported in the Statement of Financial Performance (Statement II) under “Medical Supplies and materials”. The year-end inventory balance includes shipping cost of 14%.

4.6 Prepayments and deposits

The total value of prepayments as at 31 December 2015 was US$ 12.4 million (US$ 0.4 million as at 31 December 2014). These represent payments to suppliers in advance of the receipt of goods or services. It is common practice for technical service contractors to request payments in advance to support project work. When goods or services are delivered, prepayments are applied to the appropriate expense account.

Prepayments include US$ 0.2 million of deposits (US$ 0.2 million as at 31 December 2014). Deposits represent amounts held by landlords as a security to rent office space.

4.7 Property, plant and equipment

WHO has invoked the transition provision under IPSAS 17 (Property, Plant, and Equipment) which allows a period of up to five years before requiring full recognition of property, plant and equipment. In 2015, the Organization recognized owned land and buildings at regional and country offices. All other assets were expensed upon acquisition.

As at 31 December 2015, the total value of recognized land and buildings (net of accumulated depreciation) was US$ 65.1 million (US$ 64 million as at 31 December 2014). The increase included US$ 3.3 million in new additions and ongoing construction projects.

In locations where WHO does not own the land, surface rights were granted at no cost. No value has been recognized as the Organization does not have the ability to dispose of these rights in a commercial transaction.

Major office	31 December 2014	Additions	Disposals	Impairments	Depreciation	Construction in progress	31 December 2015
	US$ thousands						
Headquarters							
Land	1 000						1 000
Buildings	39 354		(77)		(1 111)	210	38 376
Total property – Headquarters	40 354		(77)		(1 111)	210	39 376
Regional Office for Africa							
Land	14						14
Buildings	4 450	234			(195)		4 489
Total property – Regional Office for Africa	4 464	234			(195)		4 503
Regional Office for South-East Asia							
Buildings	201				(29)		172
Total property – Regional Office for South-East Asia	201				(29)		172
Regional Office for the Eastern Mediterranean							
Buildings	17 233				(340)	2 874	19 767
Total property – Regional Office for the Eastern Mediterranean	17 233				(340)	2 874	19 767
Regional Office for the Western Pacific							
Buildings	1 741				(435)		1 306
Total property – Regional Office for the Western Pacific	1 741				(435)		1 306
Total WHO							
Land	1 014						1 014
Buildings	62 979	234	(77)		(2 110)	3 084	64 110
Total property – WHO	63 993	234	(77)		(2 110)	3 084	65 124

In 2015, new equipment to the amount of US$ 22.1 million was recognized in the assets register including, for the first time, equipment from the African Region. This figure concerned only individual items with a value above US$ 5000, and are reported in the Statement of Financial Performance (Statement II) under “ Equipment vehicles and furniture”. However, as WHO is using transitional provision, these purchases were expensed upon acquisition. The transition period will expire on 31 December 2016. As on 1 January 2017, assets will be capitalized based on the remaining useful life. The opening balance for property, plant, and equipment will be restated accordingly. The details of the property, plant and equipment are shown in the table below.

Description	Total
	US$ thousands
Vehicles	15 829
Network equipment	2 054
Audio visual equipment	1 023
Office equipment	563
Computer equipment	381
Security equipment	283
Communications equipment	111
Furniture, fixtures and fittings	81
Other equipment	1 805
Total new equipment	**22 130**

4.8 Intangibles

Intangible assets held as at 31 December 2015 amounted to US$ 2.8 million (US$ 2.8 million as at 31 December 2014), most of which relates to new purchases.

Asset category	31 December 2014	Additions	Disposals/ Transfers	Impairments	Amortization	31 December 2015
			US$ thousands			
Software acquired	113	2 732			(323)	2 522
Software under development	2 689	185	(2 590)			284
Total intangible assets	**2 802**	**2 917**	**(2 590)**		**(323)**	**2 806**

4.9 Contributions received in advance

The amount for contributions received in advance mainly concerns payments received from Member States in 2015 for their 2016 assessed contributions. The balance for advance payments for voluntary contributions reflects funds received for agreements starting in 2016. Unapplied and unidentified receipts are amounts received in 2015 but not yet matched as at 31 December 2015.

Description	31 December 2015	31 December 2014
	US$ thousands	
Assessed contribution advances[a]	46 145	46 441
Advances for voluntary contributions[b]	5 587	8 465
Unapplied and unidentified receipts	4 762	6 486
Other advances	586	314
Total contributions received in advance	**57 079**	**61 707**

a. For details of the status of collection of assessed contributions, see document A69/48

b.Further details of voluntary contributions by fund and by contributor are available on the WHO programme budget web portal and on the WHO website (http://www.who.int/about/finances-accountability/funding/voluntary-contributions/en/).

4.10 Accounts payable

Accounts payable represents the total amount due to suppliers by major office as at 31 December 2015.

Description	31 December 2015	31 December 2014
	US$ thousands	
Headquarters	12 619	10 456
Regional Office for Africa	15 637	9 314
Regional Office for the Eastern Mediterranean	14 261	6 545
Regional Office for Europe	2 861	1 201
Regional Office for South-East Asia	4 664	1 704
Regional Office for the Western Pacific	3 555	2 359
Total accounts payable	**53 597**	**31 579**

4.11 Staff payable

The balance of staff payable represents the total amount outstanding to staff as at 31 December 2015. Salaries payable consist of balances due to staff pending the finalization of clearance certificates. Bank returns are balances due to staff for which the payment is pending the receipt of updated bank account information.

Description	31 December 2015	31 December 2014
	US$ thousands	
Salaries payable	1 712	1 309
Bank returns	278	220
Travel claims payable	166	248
Total staff payable	**2 156**	**1 777**

4.12 Accrued staff benefits

Accrued staff benefits include terminal payments, staff health insurance and liabilities due to service-incurred death or disability (Special Fund for Compensation).

Description	31 December 2015	31 December 2014
	US$ thousands	
Accrued staff benefits – current		
Terminal payments	46 142	55 247
Special Fund for Compensation	580	576
Total accrued staff benefits – current	**46 722**	**55 823**
Accrued staff benefits – non-current		
Terminal payments	59 388	58 479
Special Fund for Compensation	14 106	13 100
Staff health insurance	914 055	866 127
Total accrued staff benefits – non-current	**987 549**	**937 706**
Accrued staff benefits		
Terminal payments	105 530	113 726
Special Fund for Compensation	14 686	13 676
Staff health insurance	914 055	866 127
Total accrued staff benefits	**1 034 271**	**993 529**

Terminal payments

The Terminal Payments Fund was established to finance the terminal emoluments of staff members, including repatriation grants, accrued annual leave, repatriation travel and removal on repatriation. The Terminal Payments Fund is funded by a charge made to salary.

Liabilities arising from repatriation benefits and annual leave are determined by independent consulting actuaries. However, the accrued leave is calculated on a walk-away basis – that is, as if all staff separated immediately – and, therefore, is not discounted.

The most recent actuarial study (as at 31 December 2015) estimated the full terminal payment liability to be US$ 105.5 million (short-term liability, US$ 46.1 million; long-term liability, US$ 59.4 million) compared to US$ 113.7 million as at 31 December 2014. This calculation did not include costs for the end-of-service grant or for separation by mutual agreement on abolishment of posts. The defined benefit obligation amounted to US$ 67.4 million (US$ 65.2 million as at 31 December 2014) for terminal entitlements, and US$ 38.1 million (US$ 48.5 million as at 31 December 2014) for annual leave, which is included in the terminal payments current balance.

As per the actuarial study, a net reduction of US$ 8.2 million is recognized, by nature of expenses, in the Statement of Financial Performance (Statement II).

Staff health insurance

The Secretariat manages its own health insurance scheme as a separate entity. WHO's Staff Health Insurance has its own governance structure and provides for the reimbursement of a major portion of expenses for medically recognized health care incurred by staff members, retired staff members and their eligible family members. The Staff Health Insurance is financed from the contributions made by the participants (one third) and the Organization (two third) and from investment income.

The Organization accounts for after-service staff health insurance as a post-employment benefit. All gains and losses were recognized upon the adoption of IPSAS 25 (Employee Benefits). Thereafter, gains and losses (unexpected changes in surplus or deficit) will be recognized over time via the corridor method. Under this method, amounts up to 10% of the defined benefit obligation are not recognized, so as to allow gains and losses the reasonable possibility of offsetting one another over time. Gains and losses over 10% of the defined benefit obligation are amortized over the average remaining service period of active staff expected to receive each benefit.

Professional actuaries determined the 2015 defined benefit obligation for the Staff Health Insurance based on personnel data and payment experience provided by WHO. As at 31 December 2015, the unfunded defined benefit obligation amounted to US$ 914 million (US$ 866 million in 2014). As a consequence, an additional accrual of US$ 48 million was charged to staff costs.

Further details on the Staff Health Insurance liability can be found in the annual report of the Staff Health Insurance scheme.

Special Fund for Compensation

In the event of a death or disablement attributable to the performance of official duties of an eligible staff member, the Special Fund for Compensation covers all reasonable medical, hospital and other directly related costs, as well as funeral expenses. In addition, the Fund will provide compensation to the disabled staff member (for the duration of the disability) or to the surviving family members.

WHO accounts for the Special Fund for Compensation as a post-employment benefit. All gains and losses were immediately recognized upon adoption of IPSAS 25 (Employee Benefits). Thereafter, gains and losses (unexpected changes in surplus or deficit) are recognized over time via the corridor method. For accounting purposes, the plan is considered unfunded (the liability is not reduced by plan assets).

As per the actuarial study, the total liability was US$ 14.7 million at 31 December 2015 and US$ 13.7 million as at 31 December 2014. As a consequence, an additional accrual of US$ 1 million was recognized, by nature of expenses, in the Statement of Financial Performance (Statement II).

Actuarial summary of terminal payments, the Staff Health Insurance and the Special Fund for Compensation (US$ thousands)

Description	Terminal Payments (other than accrued leave)	Staff Health Insurance	Special Fund For Compensation
Reconciliation of Defined Benefit Obligation			
Defined Benefit Obligation as at 31 December 2014	65 191	1 697 955	17 438
Service cost	7 474	77 594	843
Interest cost	1 792	46 292	497
Actual Gross Benefit Payments for 2015	(5 126)	(34 070)	(667)
Actual Administrative Expenses		(2 883)	
Actual contributions by participants		10 284	
Actuarial (Gain) Loss	(1 958)	(117 159)	(2 565)
Defined Benefit Obligation as at 31 December 2015	**67 373**	**1 678 013**	**15 546**
Reconciliation of Assets			
Assets as at 31 December 2014		595 541	
Actual Gross Benefit Payments for 2015	(5 126)	(58 850)	(667)
Actual Administrative Expenses		(4 198)	
Organization Contributions during 2015	5 126	60 415	667
Participant Contributions during 2015		32 633	
Increase/Decrease in 470.1 reserve		(4)	
Expected Return on Assets		30 580	
Asset Gain (Loss)		(47 591)	
Assets as at 31 December 2015		**608 526**	
Reconciliation of Unfunded Status			
Defined Benefit Obligation			
Active	67 373	896 111	3 750
Inactive		781 902	11 796
Total defined benefit obligation	67 373	1 678 013	15 546
Plan Assets			
Gross Plan Assets		(629 376)	
Offset for WHO 470.1 Reserve		20 850	
Total plan assets		(608 526)	
Deficit (Surplus)	67 373	1 069 487	15 546
Unrecognized Gain (Loss)		(155 432)	(860)
Net Liability (Asset) Recognized in Statement of Financial Position	**67 373**	**914 055**	**14 686**
Current	7 985		580
Non-current	59 388	914 055	14 106
Net Liability (Asset) Recognized in Statement of Financial Position	**67 373**	**914 055**	**14 686**
Annual Expense for 2015			
Service Cost	7 474	77 594	843
Interest Cost	1 792	46 292	497
Expected Return on Assets		(30 580)	
Recognition of (Gain)/Loss	(1 958)	11 285	334
Total Expense Recognized in Statement of Financial Performance	**7 308**	**104 591**	**1 674**
Expected Contributions during 2016			
Contributions by WHO	8 102	20 057	590
Contributions by Participants		41 951	
Total expected contributions for 2016	**8 102**	**62 008**	**590**

Staff health insurance medical sensitivity analysis

2015 service cost plus interest cost	US$ (thousands)
Current medical inflation assumption minus 1%	94 995
Current medical inflation assumption	123 886
Current medical inflation assumption plus 1%	163 991
31 December 2015 defined benefit obligation	**US$ (thousands)**
Current medical inflation assumption minus 1%	1 380 266
Current medical inflation assumption	1 678 013
Current medical inflation assumption plus 1%	2 069 228

Actuarial methods and assumptions

Each year the Organization identifies and selects assumptions and methods that will be used by the actuaries in the year-end valuation to determine the expense and contribution requirements for the Organization's employee benefits. Actuarial assumptions are required to be disclosed in the financial statements in accordance with IPSAS 25 (Employee Benefits). In addition, each actuarial assumption is required to be disclosed in absolute terms.

The actuaries used the roll-forward method to estimate the liabilities in 2015. Normally, a full revaluation is done every three years; the next full revaluation is planned at the end of 2016.

Measurement date	
All plans:	31 December 2015
Discount rate	
Terminal payments (other than accrued leave):	The discount rate used is 3.0% (increase from 2.9% in the prior valuation). Based on the combined projected benefit payments from the prior valuation with weights of 75% on the Aon Hewitt AA Bond Universe yield curve and 25% on the SIX Swiss Exchange yield curve as of 31 December 2015. The resulting discount rate is rounded to the nearest 0.1%.
Staff health insurance:	Europe, 1.5% (decrease from 1.6% in prior valuation); the Americas, 4.5% (increase from 4.1% in prior valuation); Other Countries, 4.8% (increase from 4.4% in prior valuation. For Europe, beginning with the 31 December 2010 valuation, WHO adopted a yield curve approach to reflect the pattern of expected cash flows from the European major office. The rate is a weighted average of the 0.91% rate from the SIX Swiss Exchange curve and the 2.66% rate from the iBoxx Euro Zone curve, with a two thirds weight on the former. The resulting rate is rounded to the nearest 0.1%. For the Americas and Other Countries, the rates are determined using the Aon Hewitt AA Bond Universe curve. Beginning with the 31 December 2015 valuation, the rate for the Americas is determined in aggregate for PAHO and AMRO. The resulting rates for the Americas and Other Countries can differ, due to different patterns of expected cash flows from those regions. In all regions, the resulting rate is rounded to the nearest 0.1%.
Special Fund for Compensation:	The discount rate used is 3.7% (increase from 2.9% in the prior valuation). Based on the combined projected benefit payments from the prior valuation with weights of 75% on the Aon Hewitt AA Bond Universe yield curve and 25% on the SIX Swiss Exchange yield curve as of 31 December 2015. The resulting discount rate is rounded to the nearest 0.1%.

Annual general inflation	
Terminal payments (other than accrued leave):	The inflation rate used is 2.2%. Based on inflation rates of 2.5% for the United States of America and 1.1% for Switzerland with weights of 75% and 25%, respectively. The resulting inflation rate is rounded to the nearest 0.1%.
Staff health insurance:	Europe 1.4%, the Americas 2.5%, Other Countries 2.5%. Based on Aon Hewitt's Q3 2015 10-year forecast of global capital market assumptions. Rate for Europe is the average of rates for Switzerland (1.1%) and the rest of Europe (1.6%), rounded to the nearest 0.1%. Rate for the Americas and Other Countries is based on the 31 December 2013 valuation of the UNJSPF.
Special Fund for Compensation:	The inflation rate used is 2.2%. Based on inflation rates of 2.5% for the United States of America and 1.1% for Switzerland with weights of 75% and 25%, respectively. The resulting inflation rate is rounded to the nearest 0.1%.
Annual salary scale	
All plans:	General inflation, plus 0.5% per year productivity growth, plus merit component. Productivity and merit increases are set equal to those from the 31 December 2013 valuation of the UNJSPF.
Regional groupings for all purposes except claims costs	
Terminal payments (other than accrued leave):	Not applicable
Staff health insurance:	Based on: the Regional Office for Europe, headquarters, which are grouped as Europe; the Regional Office for the Americas constitutes the Americas; and the African Region, the Eastern Mediterranean Region, the South-East Asia Region, and the Western Pacific Region, which are grouped as Other Countries.
Special Fund for Compensation:	Not applicable
Repatriation travel and removal on repatriation	
Terminal payments (other than accrued leave):	Calculated using the projected unit credit method with service prorated, and an attribution period from the "entry on duty date" to separation.
Staff health insurance:	Not applicable
Special Fund for Compensation:	Not applicable
Repatriation grant, termination indemnity, and grant in case of death	
Terminal payments (other than accrued leave):	Using the projected unit credit method with accrual rate proration.
Staff health insurance:	Not applicable
Special Fund for Compensation:	Not applicable
Accrued leave	
Terminal payments (other than accrued leave):	The liability is set equal to the "walk-away" liability – that is, as if all staff separated immediately.
Staff health insurance:	Not applicable
Special Fund for Compensation:	Not applicable
Abolition of post, end-of-service grant, and separation by mutual agreement	
Terminal payments (other than accrued leave):	These benefits are considered termination benefits under IPSAS 25 and, therefore, are excluded from the valuation.
Staff health insurance:	Not applicable
Special Fund for Compensation:	Not applicable

United Nations Joint Staff Pension Fund

The Pension Fund's Regulations state that the Pension Board shall have an actuarial valuation made of the Fund at least once every three years by the Consulting Actuary. The practice of the Pension Board has been to carry out an actuarial valuation every two years using the Open Group Aggregate Method. The primary purpose of the actuarial valuation is to determine whether the current and estimated future assets of the Pension Fund will be sufficient to meet its liabilities.

WHO's financial obligation to the UNJSPF consists of its mandated contribution, at the rate established by the United Nations General Assembly (currently at 7.9% for participants and 15.8% for member organizations) together with any share of any actuarial deficiency payments under Article 26 of the Regulations of the Pension Fund. Such deficiency payments are only payable if and when the United Nations General Assembly has invoked the provision of Article 26, following determination that there is a requirement for deficiency

payments based on an assessment of the actuarial sufficiency of the Pension Fund as of the valuation date. Each member organization shall contribute to this deficiency an amount proportionate to the total contributions that each paid during the three years preceding the valuation date.

The actuarial valuation performed as of 31 December 2013 revealed an actuarial deficit of 0.72% (1.87% in the 2011 valuation) of pensionable remuneration, implying that the theoretical contribution rate required to achieve the balance as of 31 December 2013 was 24.42% of pensionable remuneration, compared to the actual contribution rate of 23.7%. The actuarial valuation results conducted as of 31 December 2015 are not yet available.

At 31 December 2013, the funded ratio of actuarial assets to actuarial liabilities, assuming no future pension adjustments, was 127.5% (130.0% in the 2011 valuation). The funded ratio was 91.2% (86.2% in the 2011 valuation) when the current system of pension adjustments was taken into account.

After assessing the actuarial sufficiency of the Fund, the Consulting Actuary concluded that there was no requirement, as of 31 December 2013, for deficiency payments under Article 26 of the Regulations of the Fund, as the actuarial value of assets exceeded the actuarial value of all accrued liabilities under the Fund. In addition, the market value of assets also exceeded the actuarial value of all accrued liabilities as of the valuation date. At the time of this report, the General Assembly has not invoked the provision of Article 26.

In December 2012 and April 2013, the General Assembly authorized an increase to age 65 in the normal retirement age and in the mandatory age of separation, respectively, for new participants of the Fund, with effect not later than from 01 January 2014. The related change to the Pension Fund's Regulations was approved by the General Assembly in December 2013. The increase in the normal retirement age is reflected in the actuarial valuation of the Fund as of 31 December 2013.

During 2015, WHO paid US$ 155.9 million (US$ 154.3 million in 2014) as a contribution to the UNJSPF. Expected contributions due in 2016 are US$ 150 million.

The United Nations Board of Auditors carries out an annual audit of the Pension Fund and reports to the Pension Fund Pension Board on the audit every year. The UNJSPF publishes quarterly reports on its investments and these can be viewed by visiting the UNJSPF website at www.unjspf.org.

4.13 Deferred revenue

Deferred revenue on voluntary contributions represents multi-year agreements signed in 2015 or prior years but for which the revenue recognition has been deferred to future financial periods. The balance on voluntary contributions is split into current and non-current deferred revenue, depending upon when the funds are available to the Organization to spend[1].

Deferred revenue on reimbursable procurement relates to revenue recognized where supplies or services have not been delivered to requesting parties at year-end. As reimbursable procurement is an exchange transaction, revenue is recorded on an accrual basis. The entire amount of deferred revenue for reimbursable procurement is current.

[1] Further details of voluntary contributions by fund and by contributor are available on the WHO programme budget web portal and on the WHO website (http://www.who.int/about/finances-accountability/funding/voluntary-contributions/en/).

Description	31 December 2015	31 December 2014
	US$ thousands	
Voluntary contributions	300 514	303 414
Reimbursable procurement	38 904	63 429
Total deferred revenue – current	**339 418**	**366 843**
Voluntary contributions	197 472	282 289
Total deferred revenue – non-current	**197 472**	**282 289**
Total deferred revenue	**536 890**	**649 132**

4.14 Other current liabilities

The total balance for other current liabilities as at 31 December 2015 was US$ 108.8 million (US$ 42.7 million as at 31 December 2014). The largest component is made up of the various year-end accruals totalling US$ 72.6 million, which are mainly uninvoiced receipt accruals and refunds payable relating to the balance of funds reported and due to contributors after programme implementation. Other amounts detailed in the table below include: insurance payable of US$ 13 million; other liabilities of US$ 17.6 million, which are made up of various short-term liabilities.

Description	31 December 2015	31 December 2014
	US$ thousands	
Accrual for uninvoiced goods and services	62 551	26 347
Accrual for restructuring cost	3 188	3 935
Accrued staff liability	3 469	1 841
Accrual for refunds payable	3 376	1 978
Pension payable	2 067	307
Insurance payable	12 951	2 561
Foundations	3 530	3 535
Other liabilities	17 615	2 213
Total other current liabilities	**108 747**	**42 717**

The balance for foundations concerns funds that WHO holds in trust and for whose financial and administrative management the Organization is responsible. As at 31 December 2015, the foundations with funds in trust were as follows:

- Down Syndrome Research Prize Foundation in the Eastern Mediterranean Region
- Dr A.T. Shousha Foundation
- Dr Comlan A.A. Quenum Prize for Public Health
- Ihsan Doğramacı Family Health Foundation
- Jacques Parisot Foundation
- Léon Bernard Foundation
- Francesco Pocchiari Fellowship
- Foundation for the State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern Mediterranean Region
- State of Kuwait Health Promotion Foundation
- United Arab Emirates Health Foundation
- Dr LEE Jong-wook Memorial Prize for Public Health

4.15 Inter-entity liabilities

WHO hosts a number of entities through administrative service agreements. As cash for all entities is managed by the Organization, liabilities exist with these entities for funds held on their behalf. The total amounts due per entity are as follows.

Description	31 December 2015	31 December 2014
	US$ thousands	
Staff Health Insurance	60 341	29 093
International Computing Centre	15 490	19 344
International Drug Purchase Facility	783 021	852 883
African Programme for Onchocerciasis Control	6 171	1 487
Trust Fund for the Joint United Nations Programme on HIV/AIDS	143 888	184 751
Total inter-entity liabilities	**1 008 911**	**1 087 558**

4.16 Long-term borrowings

Resolution WHA55.8 and resolution WHA56.13 authorized for construction of a new building at headquarters for the Organization and UNAIDS at an estimated cost of Swiss francs 66 million, of which WHO's share was estimated at Swiss francs 33 million. The Swiss Confederation agreed to provide an interest-free loan to the Organization and UNAIDS of Swiss francs 59.8 million, of which WHO's share is CHF 29.9 million. In the resolutions mentioned, the World Health Assembly also approved the use of the Real Estate Fund for the repayment over a 50-year period of the Organization's share of the interest-free loan provided by the Swiss Confederation with effect from the first year of the completion of the building.

The outstanding balance of the loan at 31 December 2015 was US$ 27.5 million (US$ 21.7 million at 31 December 2014) and is comprised of:

Description	31 December 2015	31 December 2014
	US$ thousands	
WHO/UNAIDS Building	21 592	21 671
WHO HQ Building	5 885	
Total Long-term borrowings	**27 477**	**21 671**

The Organization signed a new loan agreement of US$ 14 million in 2015, towards the planning phase of the updated renovation strategy for WHO's Geneva buildings following a decision WHA 67(12), out of which US$ 5.9 million is received as of 31 December 2015.

The outstanding amount for the UNAIDS building loan of US$ 21.6 million is reflected at an amortized cost using the effective interest rate of 0.7% (0.81% for 2014) applicable for the Swiss Confederation 30-year bond rate. Out of the total outstanding loan, US$ 0.6 million will be due in the next 12 months.

5. Supporting information to the Statement of Financial Performance

5.1 Revenue

Assessed contributions

Assessed contributions for 2015 were US$ 463 million[1] (US$ 492 million for 2014).

Description	31 December 2015	31 December 2014
	US$ thousands	
Assessed contributions	467 499	492 912
Increase in allowance for doubtful accounts	(4 848)	(1 046)
Assessed contributions net of allowance	**462 651**	**491 866**

In May 2013, the Sixty-sixth World Health Assembly adopted the appropriation resolution for the financial period 2014–2015,[2] in which it approved a total effective budget of US$ 3977 million. In the same resolution, the Health Assembly further resolved that the total assessment on Member States in respect of the financial period 2014–2015 would be US$ 929 million.

Following resolution WHA66.16, the assessed contributions were invoiced in Swiss francs and United States dollars for the first time in 2014. Where the total annual assessed contribution for a Member State is US$ 200 000 or greater, the contribution is assessed half in United States dollars and half in Swiss francs. Where the annual assessed contribution for a Member State is less than US$ 200 000, the contribution is assessed in United States dollars only. The annual assessment for 2015 and 2014 amounted to US$ 479 million or US$242 million and Swiss francs 222 million per year using the May 2013 exchange rate. Contributions are due from 1 January so the Swiss franc portion of the assessment was recorded at the January 2015 exchange rate, which resulted in an exchange loss on recording of US$ 12 million. As a result, the total accounted assessed contributions were US$ 467 million.

Voluntary contributions

Voluntary contributions for 2015 were US$ 1838 million (US$ 2052 million for 2014).

Description	31 December 2015	31 December 2014
	US$ thousands	
Voluntary contributions	1 839 094	2 051 885
(Increase)/decrease in allowance for doubtful accounts	(651)	26
Voluntary contributions net of allowance	**1 838 443**	**2 051 911**

These contributions represent revenue recognized from governments, intergovernmental organizations, institutions, other United Nations organizations as well as non-government organizations. Much of the revenue reported in 2015 relates to agreements that continue in future years.[3]

The figure for the total voluntary contributions reported of US$ 1838 million is after the deduction of: (i) refunds to contributors – these amounted to US$ 33.9 million (US$ 27.7 million for 2014); (ii) reductions in revenue recognized in prior years due to evidence arising in the current year that amounts will no longer be collected – these amounted to US$ 19.5 million (US$ 41.8 million for 2014); and

[1] For details of the status of collection of assessed contributions, see document A69/48.

[2] Resolution WHA66.2.

[3] Further details of voluntary contributions by fund and by contributor are available on the WHO programme budget web portal and on the WHO website (http://www.who.int/about/finances-accountability/funding/voluntary-contributions/en/).

(iii) the adjustment of payment terms with the effect of increasing deferred revenue and decreasing current revenue for revenue recognized in previous years – these amounted to US$ 1.0 million (US$ 3.8 million for 2014).

Voluntary contributions in-kind and in-service

WHO receives non-cash contributions from Member States and other contributors. In 2015, the Organization received in-kind and in-service contributions amounting to US$ 129.9 million (US$ 50.3 million as at 31 December 2014).[1]

In 2015, the in-kind and in-service expense was US$ 126.2 million (see Statement V). In-kind contributions of cholera, meningitis and yellow fever vaccines for US$3.7 million (US$ 1.08 million for 2014) received from the International Coordinating Group account for the difference between the in-kind revenue and expense. This in-kind contribution was charged to donor activities so that funds would be available under the Outbreak and Crisis Response Fund, Voluntary Fund for the future purchases of vaccines.

Description	31 December 2015	31 December 2014
	US$ thousands	
In-kind – Medical supplies and materials	96 678	22 114
In-kind – Office space	13 466	12 626
In-service	19 769	15 531
Total voluntary contributions in-kind and in-service	**129 913**	**50 271**

In addition, WHO also benefits from land made available from the host governments either at no cost or at a token rent. As the title to the land remains with the government, the use of the land is not recognized in the financial statements. The table below indicates the locations where land has been made available to WHO to construct or purchase premises.

Region	Country	City
HQ	Switzerland	Geneva
AFRO	Equatorial Guinea	Malabo
AFRO	Republic of South Sudan	Juba
EMRO	Egypt	Cairo
EMRO	Afghanistan	Kabul
EMRO	Pakistan	Islamabad
EMRO	Jordan	Amman
EMRO	Tunisia	Tunis
EMRO	Somalia	Garowe
SEARO	India	New Delhi
WPRO	Philippines	Manila

Reimbursable procurement

WHO procures medicines and vaccines on behalf of Member States and other United Nations agencies. The total revenue and expenses recognized for 2015 for reimbursable procurement was US$ 26.2 million (US$ 12.9 million for 2014) after the deduction of refunds to contributors of US$ 4.1 million (US$ 0.8 million for 2014). The balance of funds received in advance for reimbursable procurement is reported as deferred

[1] Further details of voluntary contributions by fund and by contributor are available on the WHO programme budget web portal and on the WHO website (http://www.who.int/about/finances-accountability/funding/voluntary-contributions/en/).

revenue. The revenue and expenses related to reimbursable procurement form part of the Enterprise Fund and are not reported against the programme budget.

Other operating revenue

In 2015, other operating revenue totalled US$ 18 million (US$ 15.6 million as at 31 December 2014). This mainly represented earnings generated for hosting entities such as UNAIDS, UNITAID, ICC and APOC. Other sources of earnings include the sale of publications and royalties.

5.2 Expenses

Staff costs

Staff and other personnel costs reflect the total cost of employing staff at all locations and include charges for base salary, post adjustment and any other types of entitlements (e.g. pensions and insurances) paid by the Organization. Staff costs also include the movement in the staff health insurance actuarial liability that is recognized in the Statement of Financial Performance (Statement II).

Medical supplies and materials

The majority of the balance for medical supplies and materials relates to medical supplies purchased and distributed by WHO for programme activities. Medical supplies and materials include in-kind expenses of US$ 96.7 million (US$ 22.1 million as at 31 December 2014) and reimbursable procurement related expenses of US$ 26.2 million (US$ 12.9 million as at 31 December 2014).

Contractual services

The amount for contractual services represents expenses for service providers. The main components are direct implementation, agreements for performance of work, consulting contracts or special service agreements given to individuals to perform activities on behalf of the Organization. Medical research activities, costs for fellowships, and security expenses are also considered to be contractual services.

Transfers and grants

Transfers and grants to counterparts include non-exchange contracts signed with national counterparts (mainly health ministries) and letters of agreement signed with other counterparts to perform activities that are in line with the Organization's programme budget. Transfers and grants to government ministries are also referred to as "direct financial cooperation", and are recoginsed as expenses at the time of transfer to the contractual partner. Counterparts are required to report back on the use of funds to ensure that such funds are used according to the agreement and on-site monitoring and spot checks of activities may be undertaken. WHO may withhold further funding to recipients of transfers and grants on the basis of a risk assessment or where the requirements of the agreement have not been met.

Travel

The cost of travel for WHO staff, non-staff participants in meetings, consultants and representatives of Member States paid by the Organization is included in the balance for total travel expenses. Travel expenses include airfare, per diem and other travel-related costs. This amount does not include the statutory travel for home leave or education grant that is accounted for within staff and other personnel costs.

General operating expenses

General operating expenses reflect the cost of general operations to support country offices, regional offices and headquarters including utilities, telecommunications (fixed telephone, mobile phone, Internet and global network expenses) and rents.

Equipment, vehicles and furniture

As WHO opted to use the transitional provision under IPSAS 17 (Property, Plant, and Equipment), the Organization currently expenses the full cost of equipment, vehicles and furniture at the point of delivery, excluding owned land and buildings.

Depreciation and amortization

Depreciation is the expense resulting from the systematic allocation of the depreciable amounts of property, plant and equipment over their useful lives. As of 2015, it relates to all the Organization's buildings.

Amortization is the expense resulting from the systematic allocation of the amortizable amount of intangible assets over their useful lives. As of 2015, it relates to purchased software.

5.3 Finance Revenue

Finance revenue includes the items listed in the following table:

Description	31 December 2015	31 December 2014[a]
	US$ thousands	
Investment revenue	20 820	20 128
Bank charges and investment management fees	(3 083)	(3 018)
Net realized foreign exchange gains or (losses)	284	31 680
Net unrealized foreign exchange gains or (losses)	9 020	(63 146)
Actuarial revaluation gains or (losses) on Terminal Payments Fund	3 513	28 883
Actuarial interest cost related to valuation of Terminal Payments Fund	(2 213)	(3 330)
Net total finance revenue (WHO and other entities)	**28 341**	**11 197**
Investment revenue and foreign exchange gains and losses apportioned to other entities	(7 633)	(4 585)
Total net finance revenue for WHO	**20 708**	**6 612**

a. Comparative figures have been adjusted to conform to the financial statement presentation adopted for the current year; as a result rounding differences have occurred.

Total finance revenue includes amounts related to funds administered by WHO on behalf of other entities (refer to Note 4.15). The investment income relating to other entities is allocated to those entities.

6. Supporting information to the Statement of Changes in Net Assets/Equity

6.1 Regular budget

This note provides details of financing and revenue for assessed contributions, along with the transfer made to the Tax Equalization Fund for the year 2015 (as resolved by the World Health Assembly, inter alia, in resolution WHA66.2). The status of the funds available (as shown in the table below) highlights the net surplus/ (deficit) of the Regular budget.

Description	Member States AC Fund	Tax Equalization Fund	Working Capital Fund	Total
	US$ thousands			
Balance as at 1 January 2015	**52 818**	**(8 474)**	**31 000**	**75 344**
Net Member States' assessed contributions	462 651			462 651
Tax equalization Appropriations	(14 774)	14 774		–
Finance Revenue	4 455			4 455
Miscellaneous revenue	366			366
Programmatic expenses	(477 778)			(477 778)
Tax reimbursements to staff members		(11 862)		(11 862)
Appropriation to Real Estate Fund	(10 000)			(10 000)
Balance as at 31 December 2015	**17 738**	**(5 562)**	**31 000**	**43 176**

For details regarding Assessed contributions revenue, see Note 5.1

In line with resolution WHA66.2, US$ 14.8 million was transferred to the Tax Equalization Fund, and, in line with resolution WHA 67.4, US$ 10 million was transferred to the Real Estate Fund.

In resolution WHA66.2, the Health Assembly decided that the Working Capital Fund should be maintained at its existing level of US$ 31 million.

In 2015, "Member States non-assessed income fund" was combined with "Member States AC fund".

6.2 Special Account for Servicing Costs Fund

The Special Account for Servicing Costs Fund was established in order to support the costs of servicing activities financed from sources other than the assessed contribution budget (i.e. from voluntary contributions).

The Fund is credited with revenue from the following sources:

- In accordance with resolution WHA34.17, funds are received for programme support costs from voluntary sources and are calculated by applying a fixed percentage rate to total expenses
- administrative service agreements with other entities
- interest earned on voluntary funds as described in document EB122/3

A summary of the Special Account for Servicing Cost Fund is provided below.

Description	31 December 2015	31 December 2014
	US$ thousands	
Balance as at 1 January	264 447	193 823
Revenue		
Programme support costs	169 244	143 964
Finance revenue	7 455	12 417
Administrative service agreements with other entities	6 041	5 259
Repayment of advances[a]		274
Total revenue	182 740	161 914
Expenses		
Staff and other personnel costs	80 554	58 122
Medical supplies and materials	642	490
Contractual services	16 065	11 604
Transfers and grants to counterparts	726	(2)
Travel	4 281	1 050
General operating expenses	33 039	16 031
Equipment, vehicles and furniture	8 454	3 209
Total expenses	143 761	90 504
Less:		
Increase/(decrease) in allowance for doubtful accounts receivables – voluntary contributions[b]	651	(26)
Transfers to IT Fund[c]		812
Balance as at 31 December	302 775	264 447

a. In 2014, an advance of US$ 0.3 million from the Fund was given to the secretariat of the Framework Convention on Tobacco Control. The advance was repaid in 2015.

b. In 2015, there was an increase in the allowance for doubtful accounts receivables under voluntary contributions, refer to Note 4.3.

c. In 2014, US$ 0.8 million was transferred to support IT system development and enhancements.

Expenses under the Fund by major office are as follows.

Expenses by major office	31 December 2015	31 December 2014
	US$ thousands	
Global and interregional activities	54 123	42 412
Regional Office for Africa	30 245	15 796
Regional Office for the Americas	5 756	3 721
Regional Office for the Eastern Mediterranean	15 485	11 921
Regional Office for Europe	10 718	5 736
Regional Office for South-East Asia	14 848	5 648
Regional Office for the Western Pacific	12 586	5 270
Total expenses by major office	**143 761**	**90 504**

6.3 Contingency Fund for Emergencies

This fund was established by the Sixty-eighth World Health Assembly in resolution WHA68.51.

The purpose of the fund is to provide temporary financing for emergency field operations with a target capitalization of US$ 100 million. It will be funded by voluntary contributions.

A summary of the fund is as follows.

Description	31 December 2015
	US$ thousands
Balance as at 1 January	**–**
Revenue	
Contributions	14 296
Total revenue	**14 296**
Expenses	
Travel	31
Total expenses	**31**
Balance as at 31 December	**14 265**

6.4 Enterprise Fund

This fund contains accounts for self-sustaining activities. The revenue and expenses under this fund are not included in the reporting of the programme budget. The summary of the Enterprise Fund is as follows.

Description	31 December 2015	31 December 2014
	US$ thousands	
Enterprise Fund		
Revolving Sales Fund	3 526	2 455
Concessions Fund	2 981	2 450
Insurance Policies Fund	859	1 950
Garage Rental Fund	1 999	1 248
Total Enterprise Fund	**9 365**	**8 103**

6.5 Special Purpose Fund

The accounts contained under this fund represent transfers from the General Fund or appropriations by the Health Assembly. The revenue and expenses under this fund are not included in the reporting of the programme budget. The summary of the Special Purpose Fund is as follows.

Description	31 December 2015	31 December 2014
	US$ thousands	
Special Purpose Fund		
Real Estate Fund	90 980	64 766
Building Loan Fund (refer to Notes 4.16 and 6.7)	(2 525)	
Security Fund	2 921	3 987
Information Technology Fund	12 009	8 875
Special Fund for Compensation	(7 362)	(5 629)
Terminal Payments Fund	(3 904)	(21 428)
Non-Payroll Staff Entitlements Fund	20 756	18 502
Post Occupancy Charge Fund	8 150	14 669
Internal Service Cost Recovery Fund	3 884	2 704
Staff Health Insurance Fund	(914 055)	(866 126)
Stockpiles Replenishment Fund	9 480	4 495
Polio Staff Fund	20 000	15 000
Total Special Purpose Fund	**(759 666)**	**(760 185)**

6.5.a Real Estate Fund

This fund was established by the Health Assembly in resolution WHA23.14. The Fund is used to meet the costs of: the construction of buildings or extensions to existing buildings; the acquisition of land that may be required; and major repairs and alterations to WHO's existing office buildings and to residences leased to staff by the Organization. Specific Health Assembly authorization is required for the acquisition of land and the construction of buildings or extensions to existing buildings.

The summary of the fund is as follows.

Description	31 December 2015	31 December 2014
	US$ thousands	
Balance as at 1 January	**64 766**	**33 774**
Revenue		
Appropriation received in accordance with resolution WHA67.4 and resolution WHA63.7	10 000	25 000
Transfer for special projects[a]	7 141	
Sale proceeds	4 327	
Rents collected	2 253	3 464
Other revenue	8 282	7 610
Total revenue	**32 003**	**36 074**
Expenses		
Staff and other personnel costs	94	3
Medical supplies and materials	51	27
Contractual services	1 201	1 998
Transfers and grants	26	0
Travel	10	0
General operating expenses	3 390	2 250
Equipment, vehicles and furniture	1 017	804
Total expenses	**5 789**	**5 082**
Balance as at 31 December	**90 980**	**64 766**

a. In 2015, US$ 5.2 million by AFRO and US$ 1.9 million by SEARO was transferred to the Real Estate Fund.

Expenses under the Real Estate Fund are as follows.

Description	31 December 2015	31 December 2014
	US$ thousands	
Expenses by major office		
Headquarters	2 126	2 542
Regional Office for Africa	956	1 267
Regional Office for the Americas	203	500
Regional Office for the Eastern Mediterranean	1 626	408
Regional Office for Europe	163	(132)
Regional Office for South-East Asia	231	432
Regional Office for the Western Pacific	484	65
Total expenses	**5 789**	**5 082**

6.6 Fiduciary Fund

This fund accounts for assets that are held by WHO in a trustee or agent capacity for others and that cannot be used to support the Organization's own programmes. The Fund includes the assets of the partnerships that are administered by the Organization and whose budgets are not approved by the Health Assembly. The summary of the Fiduciary Fund is as follows.

Description	31 December 2015	31 December 2014
	US$ thousands	
Fiduciary Fund		
WHO Framework Convention on Tobacco Control	7 226	9 578
Stop TB Partnership Global Drug Facility Fund		12 547
Roll Back Malaria Partnership Fund	4 540	9 987
Partnership for Maternal, Newborn and Child Health Fund	4 343	11 739
United Nations System Standing Committee on Nutrition Fund	305	989
Alliance for Health Policy and System Research Fund	15 779	18 772
Global Health Workforce Alliance Fund	2 205	2 344
Stop TB Partnership (refer to Note 6.7)	2 298	16 851
European Observatory on health systems and policies	5 417	3 048
ESPEN Fund (refer to Note 6.7)	761	
Total Fiduciary Fund	**42 874**	**85 855**

6.7 Changes to funds under Statement III (Statement of Changes in Net Assets/Equity)

As of 31 December 2015, the following new funds were established or are in the process of closing:

Building Loan Fund – A new fund created in 2015 to record and report expenses towards renovation and construction of new building in Geneva (refer to Note 4.16).

Contingency Fund for Emergencies – A new fund created in 2015 to provide temporary financing for emergency field operations (refer to Note 6.3).

ESPEN Fund – A new fund created in 2015 following the closure of APOC operations, to manage the activities for the Expanded Special Project for Elimination of Neglected Tropical Diseases (ESPEN). The project will be managed from the Regional Office for Africa.

The Stop TB Partnership and the Stop TB Partnership Global Drug Facility Fund – Effective from 1 January 2015, the administration of Stop TB Partnership has moved to the United Nations Office for Project Services. The remaining amount reported under Note 6.6 is payable to UNOPS once final settlement is agreed.

7. Supporting information to the Statement of Comparison of Budget and Actual Amounts

In May 2013, the Health Assembly adopted resolution WHA66.2 on the Programme budget 2014–2015, in which it approved the budget for the financial period 2014–2015, under all sources of funds, namely, assessed and voluntary contributions of US$ 3977 million. WHO's budget is adopted on a biennial basis by the Health Assembly. No revisions have been made to Programme budget 2014–2015. As the Organization's methodology is based on a results-based framework, the approved programme budget is measured on expenses incurred during the programme budget period.

WHO's budget and financial statements are prepared using different accounting bases. The Statement of Financial Position (Statement I), Statement of Financial Performance (Statement II), Statement of Changes in Net Assets/Equity (Statement III), and Statement of Cash Flow (Statement IV) are prepared on a full accrual basis, whereas the Statement of Comparison of Budget and Actual Amounts (Statement V) is established on a modified cash basis (i.e. actual expenses are used to measure the budget utilization).

As per the requirements of IPSAS 24 (Presentation of Budget Information in Financial Statements), the actual amounts presented on a comparable basis to the budget shall, where the financial statements and the budget are not prepared on a comparable basis, be reconciled to the actual amounts presented in the financial statements, identifying separately any differences in terms of basis, timing, entity and presentation. The General Fund, as per Note 2.17, represents the programme budget results, except for the Tax Equalization Fund expenses, other non-programme budget utilization and all in-kind/in-service expenses that are not included in the programme budget results.

Explanations of material differences between the final budget and the actual amounts by Category and Programme Area are available in section 1 of this document.

As required by IPSAS 24, reconciliation is provided on a comparable basis between the actual amounts as presented in Statement V and the actual amounts in the financial accounts identifying separately any basis, timing, entity and presentation differences.

Basis differences occur when the components of the approved programme budget are used for activities other than the implementation of technical programmes. Examples of this include Tax Equalization Fund expenses, other non-programme budget utilization and special arrangements.

Timing differences represent the inclusion in WHO's financial accounts of programme budget expenses in other financial periods.

Entity differences represent the inclusion in WHO's financial accounts of the amounts against two funds: Member States – other and the Fiduciary Fund. These funds do not form part of the Organization's programme budget.

Presentation differences concern differences in the format and classification schemes in the Statement of Cash Flow (Statement IV) and the Statement of Comparison of Budget and Actual Amounts (Statement V).

A reconciliation between the actual amounts on a comparable basis in Statement V and the actual amounts in Statement IV for December 2015 is presented below.

Description	2015			
	Operating	Investing	Financing	Total
	US$ thousands			
Actual amount on a comparable basis (Statement V)	(2466 677)			(2466 677)
Basis differences	71 579	87 718	5 281	164 578
Timing differences				
Entity differences	200 188	(22 982)		177 206
Presentation differences	1 926 888	(3 568)		1 923 320
Actual amount in the Statement of Cash Flow (Statement IV)	**(268 022)**	**61 168**	**5 281**	**(201 573)**

8. Segment reporting

8.1 Statement of Financial Position by segments

As at 31 December 2015 (In thousands of US dollars)

Description	Headquarters	Regional Office for Africa	Regional Office for the Americas	Regional Office for the Eastern Mediterranean	Regional Office for Europe	Regional Office for South-East Asia	Regional Office for the Western Pacific	Total
ASSETS								
Current assets								
Cash and cash equivalents	387 384	24 520		11 837	1 516	2 401	3 660	431 318
Short-term investments	2 754 259							2 754 259
Receivables - current	864 307	616	123	139	451	283	97	866 016
Staff receivables	497	5 066		1 603	622	1 138	1 776	10 702
Inventories	29 203	2 001		20 213		706	1 029	53 152
Prepayments and deposits	8 150	544		2 011	34	1 454	281	12 474
Other current assets	454 845		(454 845)					
Total current assets	4 498 645	32 747	(454 722)	35 803	2 623	5 982	6 843	4 127 921
Non-current assets								
Receivables - non-current	197 472							197 472
Long-term investments	93 900							93 900
Property, plant and equipment	39 375	4 504		19 767		172	1 306	65 124
Intangibles	2 761					45		2 806
Total non-current assets	333 508	4 504		19 767		217	1 306	359 302
TOTAL ASSETS	4 832 153	37 251	(454 722)	55 570	2 623	6 199	8 149	4 487 223
LIABILITIES								
Current liabilities								
Contributions received in advance	56 740	339						57 079
Accounts payable	12 619	15 637		14 261	2 861	4 664	3 555	53 597
Staff payable	902	611		305	24	158	156	2 156
Accrued staff benefits - current	21 095	12 369		4 253	2 798	2 956	3 251	46 722
Deferred revenue	339 418							339 418
Financial liabilities	53 177							53 177
Other current liabilities	(10 570 758)	4 705 502	125 131	2 559 403	850 282	1 394 546	1 044 641	108 747
Inter-entity liabilities	1 008 911							1 008 911
Total current liabilities	(9 077 896)	4 734 458	125 131	2 578 222	855 965	1 402 324	1 051 603	1 669 807
Non-current liabilities								
Long-term borrowings	27 477							27 477
Accrued staff benefits - non-current	563 820	163 086		56 297	82 436	65 551	56 359	987 549
Deferred revenue - non-current	197 472							197 472
Total non-current liabilities	788 769	163 086		56 297	82 436	65 551	56 359	1 212 498
TOTAL LIABILITIES	(8 289 127)	4 897 544	125 131	2 634 519	938 401	1 467 875	1 107 962	2 882 305
NET ASSETS/EQUITY								
Regular budget	2 464 005	(810 592)	(324 200)	(342 644)	(247 544)	(392 007)	(303 842)	43 176
Voluntary funds	10 593 112	(3 850 554)	(241 013)	(2 064 603)	(578 885)	(990 939)	(700 963)	2 166 155
Member States - other	11 067	(198 815)	(14 427)	(171 527)	(100 304)	(78 426)	(94 855)	(647 287)
Fiduciary funds	53 096	(332)	(213)	(175)	(9 045)	(304)	(153)	42 874
TOTAL NET ASSETS/EQUITY	13 121 280	(4 860 293)	(579 853)	(2 578 949)	(935 778)	(1 461 676)	(1 099 813)	1 604 918
TOTAL LIABILITIES AND NET ASSETS/EQUITY	4 832 153	37 251	(454 722)	55 570	2 623	6 199	8 149	4 487 223

8.2 Statement of Financial Performance by segments

For the year ended 31 December 2015
(In thousands of US dollars)

Description	Headquarters	Regional Office for Africa	Regional Office for the Americas	Regional Office for the Eastern Mediterranean	Regional Office for Europe	Regional Office for South-East Asia	Regional Office for the Western Pacific	Total
Revenue								
Assessed contributions	462 651							462 651
Voluntary contributions	1 838 415				28			1 838 443
Voluntary contributions in-kind and in-service	51 259	39 112		6 650	4 977	25 791	2 124	129 913
Reimbursable procurement	26 170							26 170
Other revenue	26 796	(2 866)	(2 707)	(884)	(862)	(798)	(714)	17 965
Total revenue	2 405 291	36 246	(2 707)	5 766	4 143	24 993	1 410	2 475 142
Expenses								
Staff costs	418 841	214 158	42 896	79 775	63 055	47 590	53 876	920 191
Medical supplies and materials	46 141	75 375	6 691	82 753	2 887	41 523	10 111	265 481
Contractual services	216 896	233 905	14 587	155 031	38 465	52 656	32 556	744 096
Transfers and grants	17 939	164 524	4 931	81 542	5 475	17 176	20 130	311 717
Travel	102 388	63 195	13 593	17 846	12 801	12 556	11 160	233 539
General operating expenses	61 423	67 324	4 153	26 005	12 305	14 426	7 635	193 271
Equipment, vehicles and furniture	8 573	26 956		16 952	2 928	8 024	4 283	67 716
Depreciation and amortization	1 366	195		340		97	435	2 433
Total expenses	873 567	845 632	86 851	460 244	137 916	194 048	140 186	2 738 444
Finance revenue	19 624	1 268	12	128	162	(429)	(57)	20 708
TOTAL (DEFICIT)/SURPLUS FOR THE YEAR	1 551 348	(808 118)	(89 546)	(454 350)	(133 611)	(169 484)	(138 833)	(242 594)

Note. The revenue balance shows a high surplus for headquarters and deficits for other offices. This is a consequence of the policy of centralized accounting for revenue and decentralized accounting for expenses.

9. Amounts written-off and ex-gratia payments

No write-off was approved in 2015.

During 2015, a total of US$ 84 435 was approved as ex-gratia payment (Nil in 2014). The balance represent three separate payments:

(1) US$ 68 500 was approved towards the rehabilitation grant to earthquake affected staffs (24) in Nepal;

(2) US$12 735 was paid as a death compensation to the heirs of an APW contractor in Pakistan; and

(3) US$ 3 200 was paid as funeral expenses for an individual who died in the vicinity of WHO premises in the Regional Office for Africa.

10. Related party and other senior management disclosures

Staff members considered to be "key management personnel" are the Director-General, regional directors and all other ungraded staff.

The number of key management personnel who held these positions over the course of the year was 22. The table below details their aggregate remuneration.

Description	US$ thousands
Compensation and post adjustment	4 116
Entitlements	320
Pension and health plans	1 032
Total remuneration	**5 468**
Outstanding advances against entitlements	**42**
Outstanding loans (in addition to normal entitlements, if any)	**–**

The aggregate remuneration of key management personnel includes: net salaries, post adjustment, entitlements such as representation allowance and other allowances, assignment and other grants, rental subsidy, personal effects shipment costs, and employer pension and current health insurance contributions.

Key management personnel are also qualified for post-employment benefits at the same level as other employees. These benefits cannot be reliably quantified. Key management personnel are ordinary members of the UNJSPF.

The Regional Director for the Americas is included among the key management personnel. However, as the Regional Director is receiving all entitlements and benefits from PAHO, the entitlements and benefits concerned are disclosed in PAHO's financial statements and not in WHO's financial statements.

During the year, no loans were granted to key management personnel beyond those widely available to staff outside this grouping.

11. Events after the reporting date

WHO's reporting date is 31 December 2015. On the date of the signing of these accounts, no material events, favourable or unfavourable, had arisen between the balance sheet date and the date when the financial statements were authorized for issue that would have had an impact on the financial statements.

12. Contingent liabilities, commitments and contingent assets

Contingent liabilities

As at 31 December 2015, WHO had a number of legal cases pending. Most involve disputes that are not recorded because the likelihood of repayment has been determined to be remote. However, there are four cases involving contractual disputes that are to be considered contingent liabilities. The total potential cost to the Organization is estimated at US$ 24 040 (US$ 98 192 as at 31 December 2014).

Operating leases commitments

WHO enters into operating lease arrangements for renting office space in various country offices. Future minimum lease rental payments for the following periods are as follows.

Description	2015	2014
	US$ thousands	
Under 1 Year	6 015	4 713
1 to 5 years	7 705	7 702
5 years +	1 260	1 995
Total lease commitments	**14 980**	**14 410**

The Organization has no outstanding leases qualifying as finance leases at the reporting date.

WHO leased office space to seven tenants. As at 31 December 2015, total revenue from the leasing activities was US$ 1 million (US$ 1.3 million as at 31 December 2014).

Contingent assets

In accordance with IPSAS 19 (Provisions, Contingent Liabilities and Contingent Assets), contingent assets will be disclosed for cases where an event will give rise to a probable inflow of economic benefits. As at 31 December 2015, there are no material contingent assets to disclose.

Schedule I. Statement of Financial Performance by major funds

For the year ended 31 December 2015
(In thousands of US dollars)

Description	General Fund				Member States -other			Fiduciary Fund	Subtotal	Eliminations[a]	Total	Percentage
	Regular budget	Voluntary funds	Eliminations[a]	Subtotal	Common Fund	Enterprise Fund	Special Purpose Fund					
Revenue												
Assessed contributions	462 651			462 651							462 651	19%
Voluntary contributions		1 836 320		1 836 320				5 443	5 443	(3 320)	1 838 443	74%
Voluntary contributions in-kind and in-service		3 749		3 749		126 164			126 164		129 913	5%
Reimbursable procurement						26 170			26 170		26 170	1%
Other revenue	(9 633)	176 978	(163 927)	3 418	(278)	4 593	205 442	(1 693)	208 064	(193 517)	17 965	1%
Total operating revenue	453 018	2 017 047	(163 927)	2 306 138	(278)	156 927	205 442	3 750	365 841	(196 837)	2 475 142	100%
Expenses												
Staff costs	350 819	557 449		908 268		22 060	143 030	17 503	182 593	(170 670)	920 191	34%
Medical supplies and materials	9 446	155 703		165 149	(2 733)	101 964	4 807	747	104 785	(4 453)	265 481	10%
Contractual services	52 440	657 117		709 557	(8 149)	505	31 985	17 113	41 454	(6 915)	744 096	27%
Transfers and grants	18 831	292 946		311 777		2 025	26	1 113	3 164	(3 224)	311 717	11%
Travel	27 859	198 483		226 342		107	2 452	4 777	7 336	(139)	233 539	9%
General operating expenses	23 334	291 888	(163 927)	151 295		27 183	19 915	5 517	52 615	(10 639)	193 271	7%
Equipment, vehicles and furniture	6 911	58 957		65 868	(4 249)	1 821	5 010	63	2 645	(797)	67 716	2%
Depreciation and amortization					2 433				2 433		2 433	0%
Total expenses	489 640	2 212 543	(163 927)	2 538 256	(12 698)	155 665	207 225	46 833	397 025	(196 837)	2 738 444	100%
Finance revenue	4 454	7 854		12 308	5 996		2 302	102	8 400		20 708	
TOTAL (DEFICIT)/SURPLUS FOR THE YEAR	(32 168)	(187 642)		(219 810)	18 416	1 262	519	(42 981)	(22 784)		(242 594)	
Fund balance – 1 January 2015	75 344	2 353 797		2 429 141	84 598	8 103	(760 185)	85 855	(581 629)		1 847 512	
Fund balance – 31 December 2015	43 176	2 166 155		2 209 331	103 014	9 365	(759 666)	42 874	(604 413)		1 604 918	

a. Eliminations as reported in the "Statement of financial performance by major fund (Schedule 1)" are accounting adjustments made to remove the effect of inter-fund transfers that would otherwise overstate revenue and expenses of the Organization. These accounting adjustments are done through a separate elimination fund established for this purpose.

Schedule II. Expenses by major office – General Fund only

For the year ended 31 December 2015
(In thousands of US dollars)

Description	Headquarters	Regional Office for Africa	Regional Office for the Americas	Regional Office for the Eastern Mediterranean	Regional Office for Europe	Regional Office for South-East Asia	Regional Office for the Western Pacific	Total
Expenses								
Staff costs	393 048	223 036	45 369	81 386	53 481	53 105	58 843	908 268
Medical supplies and materials	22 982	39 063	6 467	72 907	2 755	15 747	5 228	165 149
Contractual services	189 971	228 111	11 617	157 509	37 227	54 024	31 098	709 557
Transfers and grants	20 050	162 499	4 931	81 516	5 475	17 176	20 130	311 777
Travel	97 503	62 432	13 303	17 399	12 302	12 411	10 992	226 342
General operating expenses	34 462	61 492	4 092	22 517	7 009	15 346	6 377	151 295
Equipment, vehicles and furniture	8 247	24 904		18 498	2 924	7 724	3 571	65 868
Total expenses	766 263	801 537	85 779	451 732	121 173	175 533	136 239	2 538 256
Percentage of expenses by expense type across major office								
Staff and other personnel costs	43%	25%	5%	9%	6%	6%	6%	100%
Medical supplies and materials	14%	24%	4%	44%	2%	10%	3%	100%
Contractual services	27%	32%	2%	22%	5%	8%	4%	100%
Transfers and grants to counterparts	6%	52%	2%	26%	2%	6%	6%	100%
Travel	43%	28%	6%	8%	5%	5%	5%	100%
General operating expenses	23%	41%	3%	15%	5%	10%	4%	100%
Equipment, vehicles and furniture	13%	38%	0%	28%	4%	12%	5%	100%
Total percentage	30%	32%	3%	18%	5%	7%	5%	100%
Percentage of expenses by expense type within each major office								
Staff and other personnel costs	51%	28%	53%	18%	44%	30%	43%	36%
Medical supplies and materials	3%	5%	8%	16%	2%	9%	4%	7%
Contractual services	25%	28%	14%	35%	31%	31%	23%	28%
Transfers and grants to counterparts	3%	20%	6%	18%	5%	10%	15%	12%
Travel	13%	8%	16%	4%	10%	7%	8%	9%
General operating expenses	4%	8%	5%	5%	6%	9%	5%	6%
Equipment, vehicles and furniture	1%	3%	0%	4%	2%	4%	3%	3%
Total percentage	100%	100%	100%	100%	100%	100%	100%	100%

ANNEX 1

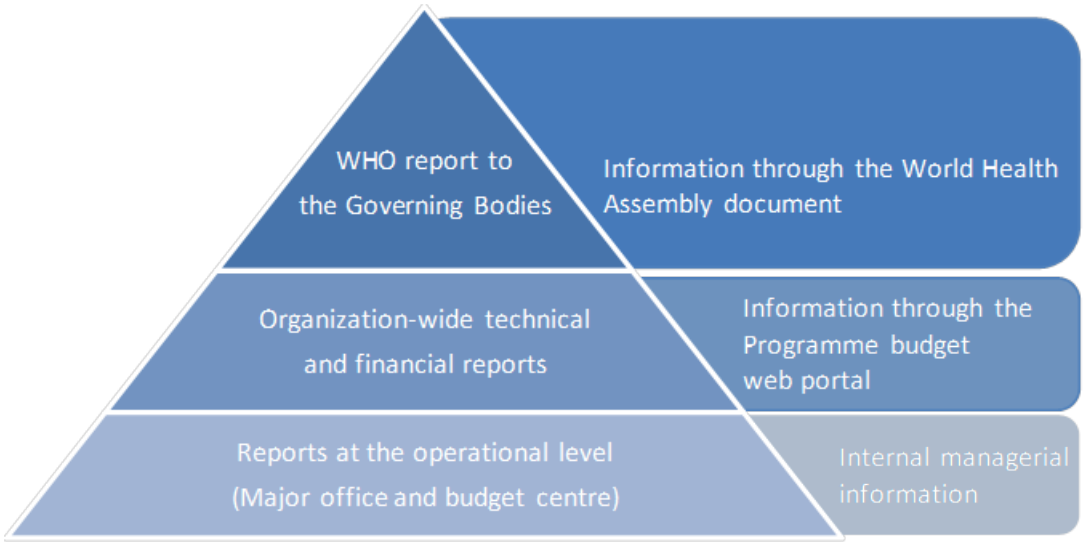
PROGRAMME BUDGET 2014–2015
PERFORMANCE ASSESSMENT METHODOLOGY

The programme budget performance assessment is the final stage of the biennial programme budget implementation cycle. It is a systematic review of the work performed by the Secretariat, by programme area and across the three levels of the Organization. All budget centres assess the delivery of work contained in workplans (i.e. products and services) as a contribution to the outputs stated in the approved programme budget.

The methodology followed is a stepwise and incremental synthesis. At end of each step, information is consolidated and goes through reviews at major office level and by programme area and category networks. The steps include a review of the output indicators and programme area and category reports – at major office level and Organization-wide – conducted by the respective networks as well as by senior management. Three hundred budget centres, of which 149 are country offices, the six regional offices and headquarters participate in the process. Standard templates, guidance notes and checklists are used. This process and the gathering of information have several purposes, which include completion of system-wide required assessment and analysis of lessons learnt, closure of workplans and production of statutory reports to the Health Assembly.

The process starts in the final months of the biennium and concludes in March of the subsequent biennium, with internal reports and a summary report (in the six official languages) submitted to the Health Assembly in May. The detailed reports include information on achievement of output indicators and notes on indicators, explanations of output ratings by major office, details of risks and assumptions, integration of gender, equity and human rights and social determinants of health approaches, and examples of efficiency savings.

Figure. Schematic representation of the performance assessment process



The programme budget performance assessment for 2014–2015 is the first end-of-biennium exercise to be undertaken under the Twelfth General Programme of Work (2014–2019). It is also the first assessment of the implementation of the programme budget based on the new results chain, one of the major products of the WHO programmatic reform. In continuation of implementation of the reform, and for the first time, a combined programmatic and financial report on implementation of the programme budget is being presented to the Health Assembly. This is a major step forward in the way WHO is communicating the results of the programme budget performance assessment.

The improvement in the process and outcome of the programme budget performance assessment for 2014–2015, when compared to that for 2012–2013, includes the following:

- A unified, well-defined process and continuity were ensured by linking to the progress and findings reported during the mid-term review.
- Improved transparency and accountability were further strengthened through presentation of detailed reports on the programme budget web portal.
- The assessment is based not only on the achievement of the performance indicators but also the delivery of products and services, assessment of risks and mitigation strategies identified, and the use of human and financial resources.
- Responsible officers at the three levels have verified the reports with relevant documentation that can be used as evidence for validation/verification during internal and external reviews and audits.
- Quality assurance was applied by the use of standard templates, checklists and iterative reviews to assist managers, programme area leads and category leads, respectively.

The rating of the extent to which the outputs were delivered or contributed to by a major office is indicated with (✓) for fully delivered/contributed; (!) for partly delivered/contributed; (X) for not delivered/contributed; and (n/a) for not applicable. The rating n/a was given in those cases where major offices reported that the contribution to an output is not a regional priority or the particular output is not relevant for the regional situation.

The unified programmatic and financial report for 2014–2015, complemented by the information published on the programme budget web portal, is a notable step forward. Future improvements will build on this milestone to further strengthen and streamline the process and enable further consolidation with other assessments, including external evaluations, administrative reviews and integrated country audits.

ANNEX 2

GLOSSARY OF TERMS

Accrual basis is the accounting basis under which transactions and other events are recognized when they occur (and not only when cash or its equivalent is received or paid). Therefore, transactions and events are recorded in the accounting records and recognized in the financial statements of the periods to which they relate. The elements recognized under accrual accounting are assets, liabilities, net assets/equity, revenue and expenses.

Achievement is: (a) the actual change that results from delivering a programme or implementing an intervention; and (b) the actual value of a performance indicator measured at any point of time.

Assets are resources controlled by an entity as a result of past events and from which future economic benefits or service potential are expected to flow to the entity. Assets used to deliver goods and services in accordance with an entity's objectives, but which do not directly generate net cash inflows, are often described as having a service potential.

Accounting policies are the specific principles, bases, conventions, rules and practices applied by an entity in preparing and presenting financial statements.

Actuarial gains and losses comprise: (a) experience adjustments (the effects of differences between the previous actuarial assumptions and what has actually occurred); and (b) the effects of changes in actuarial assumptions.

Amortization is the systematic allocation of the amortizable amount of an intangible asset over its estimated useful life.

Appropriation is an authorization granted by a legislative body to allocate funds for purposes specified by the legislature or similar authority. For WHO, appropriations are voted by the World Health Assembly.

Cash equivalents are short-term, highly liquid investments that are readily convertible to known amounts of cash and that are subject to an insignificant risk of changes in value.

Class of property, plant and equipment is a grouping of assets of a similar nature or function in an entity's operations that is shown as a single item for the purpose of disclosure in the financial statements.

Contingent asset is a possible asset that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the entity.

Contingent liability is: (a) a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the entity; or (b) a present obligation that arises from past events but which is not recognized because it is not probable that an outflow of resources embodying economic benefits or service potential will be required to settle the obligation or because the amount of the obligation cannot be measured with sufficient reliability.

Depreciation is the systematic allocation of the depreciable amount of a tangible asset over its estimated useful life.

Employee benefits are all forms of consideration given by an entity in exchange for service rendered by employees. Employee benefits mean all entitlements, salaries, allowances, benefits and incentives.

Exchange transactions are transactions in which one entity receives assets or services, or has liabilities extinguished, and directly gives approximately equal value (primarily in the form of cash, goods, services, or use of assets) to another entity in exchange.

Fair value is the amount for which an asset could be exchanged, or a liability settled, between knowledgeable, willing parties in an arm's length transaction.

Functional currency is the currency of the primary economic environment in which the entity operates. For WHO this is considered to be the US dollar.

Funds available comprise the amount carried over from the prior biennium and the revenue received within the current biennium.

Impact is a sustainable change in the health of populations to which the Secretariat and Member States contribute.

Impairment is a loss in the future economic benefits or service potential of an asset, over and above the systematic recognition of the loss of the asset's future economic benefits or service potential through depreciation.

Intangible assets are identifiable non-monetary assets without physical substance.

Interest cost is the increase during a financial period in the present value of a defined benefit obligation which arises because the benefits are one period closer to settlement.

Inventories are assets: (a) in the form of materials or supplies to be consumed in the production process; (b) in the form of materials or supplies to be consumed or distributed in the rendering of services; (c) held for sale or distribution in the ordinary course of operations; or (d) in the process of production for sale or distribution. Care should be taken to avoid confusion when using the word "inventory". Property, plant and equipment are not inventory as defined above, although they may be inventoried by being counted and physically verified.

Key management personnel are defined under International Public Sector Accounting Standards as those officials who are responsible for the planning, directing and controlling activities of the reporting entity.

Lease is an agreement whereby the lessor conveys to the lessee in return for a payment or series of payments the right to use an asset for an agreed period of time.

Liabilities are present obligations of an entity arising from past events, the settlement of which is expected to result in an outflow from the entity of resources embodying economic benefits or service potential.

Net assets/equity is the residual interest in the assets of an entity after deduction of all its liabilities. This is the residual measure in the statement of financial position.

Net realizable value is the estimated selling price in the ordinary course of operations less the estimated costs of completion and the estimated costs necessary to make the sale, exchange or distribution.

Non-exchange transactions are transactions that are not exchange transactions. In a non-exchange transaction, an entity either receives value from another entity without directly giving approximately equal value in exchange, or gives value to another entity without directly receiving approximately equal value in exchange.

Operating lease is a lease other than a finance lease.

Outcomes represent changes in the institutional and behavioural capacities for development conditions that occur between the completion of outputs and the achievement of impacts.

Outputs are changes in skills or abilities and capacities of individuals or institutions, or the availability of new products and services, that result from the completion of activities within the control of the Secretariat. They are achieved with the resources provided and within the time period specified.

Performance indicator: a unit of measurement that specifies what is to be measured along a scale or dimension. Performance indicators are a qualitative or quantitative means of measuring an output or outcome, with the intention of gauging the performance of a programme or investment.

Property, plant and equipment, or PP&E, are tangible items that are: (a) held for use in the production or supply of goods or services, for rental to others or for administrative purposes; and (b) expected to be used during more than one reporting period. PP&E should not be confused with inventories as defined above, although they may be counted and physically verified.

Provision is a liability of uncertain timing or amount.

Related parties are parties considered to be related if one party has the ability to control, or exercise significant influence over, the other party in making financial and operating decisions, or if the related party entity and another entity are subject to common control.

Revenue is the gross inflow of economic benefits or service potential during the reporting period when those inflows result in an increase in net assets/equity other than increases relating to contributions from owners.

Risk corresponds to a potential future event, fully or partially beyond control, that may negatively affect the achievement of results.

Segment is a distinguishable activity or group of activities of an entity for which it is appropriate to separately report financial information for the purpose of evaluating the entity's past performance in achieving its objectives and for making decisions on the future allocation of resources.

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World Health Organization