SIXTY-FIFTH WORLD HEALTH ASSEMBLY
Provisional agenda item 16.1

A65/28
11 May 2012

Programme budget 2010–2011: performance assessment

Summary report

FOREWORD BY THE DIRECTOR-GENERAL

1. This document provides a systematic assessment of WHO's performance during the biennium 2010–2011 according to each of the Organization's 13 strategic objectives that are set out in the programme budget for that period. Its preparation is in line with my personal commitment to results-based management and to accountability in the use of resources as measures for improving the performance of WHO.

2. As I have often noted, better health outcomes within individual countries, especially for women and the people of Africa, are the most important measure of WHO's overall performance. This document records such results, but also reports on progress within countries in building capacities and applying norms and standards developed by WHO. The impact of this normative work is particularly evident for strategic objective 11, on the improved access, quality and use of medical products and technologies, but also occurs in many other WHO programmes and activities. Norms and standards contribute to equity. Everyone deserves the same assurance that the air they breathe, the water they drink, the food they eat, the medicines they take, and the chemicals they encounter will not harm their health. Most health professionals know that young-child mortality worldwide has declined sharply since the start of this century, but few may be aware that 64% of the global infant population is now immunized with vaccines prequalified by WHO.

3. This assessment is issued at a time when WHO is undergoing comprehensive programmatic, managerial, and administrative reforms, and has lessons that can guide this process. Progress towards the health-related Millennium Development Goals continues to demonstrate the value of focusing international health cooperation on a limited number of time-bound goals. Some achievements recorded in this document are particularly striking. Young-child deaths dipped to a historically unprecedented low in 2010 and the downward trend continues. Though still too high, stubborn numbers of maternal deaths have likewise begun to fall. Nearly 50% of pregnant women living with HIV saw their babies born free of the virus due to appropriate antiretroviral therapy. The number of people falling ill with tuberculosis continued the steady decline first observed in 2006. For malaria, the number of cases and deaths declined by at least 50%, compared with 2000, in 43 countries. An estimated 800 million people received preventive chemotherapy for at least one of the neglected tropical diseases in a single year of the biennium. Investment in health development is working, but we must never forget the fragility of this progress, especially at a time of widespread financial austerity.

4. The biggest shift during the biennium came with high-level political acknowledgement of the multiple threats, also to economies, posed by the rise of chronic noncommunicable diseases. This acknowledgement included recognition of the need for collaboration among multiple sectors of government and multiple agencies well beyond health. Progress in developing protocols for implementing provisions of the WHO Framework Convention on Tobacco Control demonstrated that full cooperation, in the name of health, with ministries of finance, trade, labour, and agriculture as well as law enforcement bodies is entirely feasible and profoundly fruitful.

5. At a time of global financial upheaval, maintaining the striking momentum for better health that marked the start of the century calls for a shift to thrift. Health programmes, whether national or international, must develop a thirst for efficiency and an intolerance of waste. Given the current high interest in improving the performance of health systems, publication of *The world health report 2010* on health system financing was well timed; its emphasis on moving towards universal coverage was opportune. The world has recently opened its eyes to the destabilizing effects of social inequalities. Universal coverage is a powerful equalizer that contributes to social cohesion and stability. I have

been deeply encouraged by the number of countries that have embarked on the path towards universal coverage. Many are using *The world health report* for inspiration as well as practical guidance.

6. In my view, the quest for greater efficiency should look to innovation for some answers. Health during the biennium benefited, in countries and at the international level, from several innovations, in the form of new medical products as well as new instruments for improving global health governance. The new meningitis conjugate vaccine, developed in a project coordinated by WHO and PATH, and launched in 2010, reached 33 million people, resulting in the lowest number of confirmed meningitis A cases recorded during an epidemic season in Africa's meningitis belt. With support from WHO, 25 African countries implemented a "fast track" registration and licensing procedure for the new vaccine. A new molecular test for rapid and more precise diagnosis of tuberculosis was rolled out with WHO guidance, at a price that had been vastly reduced following WHO endorsement. The number of countries introducing the new pneumococcal and rotavirus vaccines, offering protection against the two biggest killers of young children, continued to grow.

7. The Commission on Information and Accountability for Women's and Children's Health broke new ground in terms of global health governance. Its strategy of improving basic information capacity within countries as the bedrock of accountability has served as a model for developing targets and indicators for monitoring progress in combating noncommunicable diseases. After years of intense negotiations, Member States adopted a framework that sets out obligations for the sharing of influenza viruses and of benefits, like vaccines and medicines, during an influenza pandemic. A Review Committee, set up under the International Health Regulations (2005), assessed WHO performance during the 2009 influenza pandemic and issued recommendations aimed at improving the global response to similar events in the future. As yet another instrument to improve performance and accountability, an Independent Monitoring Board was established to oversee progress in polio eradication. The Board's six-monthly assessments have been frank, critical, and taken very seriously by countries as well as by WHO and its partners in the Polio Eradication Initiative.

8. As I like to say, what gets measured gets done. As the reform process continues, Member States are looking at ways to measure the results of WHO's work more precisely, at the same time simplifying, streamlining, and rationalizing procedures for setting priorities. Future assessments of WHO's performance will no doubt draw on these most welcome reforms.

PERFORMANCE ASSESSMENT PROCESS

9. The Programme budget 2010–2011 performance assessment is the second to be carried out within the framework of the Medium-term strategic plan 2008–2013. This assessment report provides an analysis of the achievement of the Organization-wide expected results and performance indicators set out in the amended Medium-term strategic plan 2008–2013 that was endorsed by the Sixty-second World Health Assembly. The purpose of the exercise was to evaluate the Secretariat's contribution to the achievement of the Organization-wide expected results by Member States.

10. Similarly to previous bienniums, the assessment exercise was a self-assessment process. Individual offices (country, regional and headquarters) assessed their performance in achieving the office-specific expected results and their indicators through the delivery of planned products and services. Narrative information on the achievements, lessons learnt and way forward was provided. Each major office submitted an assessment of the regional and headquarters' contributions to the achievement of Organization-wide expected results. Findings from across the Organization were then consolidated in order to produce Organization-wide assessment reports. The exercise was coordinated

by the strategic objective teams. One of the major requirements was the provision of evidence relating to the agreed performance indicators. The achievements in countries were given particular attention.

11. In order to improve the consistency and reliability of the assessment report, quality assurance mechanisms were established. The draft Organization-wide assessment reports were reviewed by regional teams and the Organization-wide strategic objective teams, as well as by a peer review group consisting of technical unit representatives and the planning and performance assessment team. The strategic objective reports were scrutinized to ensure the accuracy of the Secretariat's contribution and the overall achievement of the Organization-wide expected results by Member States. The feedback on the review process was incorporated in the final Organization-wide assessment reports, which provided the basis for the current summary document, as well as for the full report, which is available upon request.

OVERVIEW OF ORGANIZATION-WIDE EXPECTED RESULTS

12. Table 1 shows the profile of achievement of the Organization-wide expected results by strategic objective. Out of a total of 85 Organization-wide expected results for the biennium 2010–2011, 46 were considered to have been "fully achieved" and 39 "partly achieved".

13. Achievement of the Organization-wide expected results was assessed primarily on the basis of the achievement of indicators. In making the assessment, the baseline and target values were adjusted to reflect the 2008–2009 actual achievements reported in the Programme budget 2008–2009 performance assessment. In some cases, the baselines and targets were also updated to reflect further clarification of the definitions and measurement criteria for individual indicators.

14. Based on the updated baselines and targets, the Organization-wide expected results were assessed as follows:

- Fully achieved – All indicator targets for the Organization-wide expected result were met or surpassed.

- Partly achieved – One or more indicator targets for the Organization-wide expected result were not met.

- Not achieved – No indicator target for the Organization-wide expected result was met.

15. In addition, the contribution of each major office was taken into consideration. For an expected result to be assessed as "fully achieved" at least six of the seven major offices would have reported their contribution as "fully achieved". If two or more of the seven major offices indicated a partial achievement of their expected results owing to certain obstacles and impediments they faced during the reporting period then the overall assessment was rated "partly achieved".

Table 1. Programme budget 2010–2011, achievement of Organization-wide expected results, by strategic objective

Strategic objective	Organization-wide expected results		
	Fully achieved	Partly achieved	Total
1. Communicable diseases	4	5	9
2. HIV/AIDS, tuberculosis and malaria	1	5	6
3. Chronic noncommunicable conditions	3	3	6
4. Child, adolescent, maternal, sexual and reproductive health, and ageing	6	2	8
5. Emergencies and disasters	3	4	7
6. Risk factors for health	5	1	6
7. Social and economic determinants of health	2	3	5
8. Healthier environment	4	2	6
9. Nutrition and food safety	3	3	6
10. Health systems and services	7	6	13
11. Medical products and technologies	2	1	3
12. WHO leadership, governance and partnerships	4	0	4
13. Enabling and support functions	2	4	6
Total	**46**	**39**	**85**

SUMMARY OF FINANCIAL IMPLEMENTATION

16. The biennium 2010–2011 presented challenges in the form of lower than expected voluntary contributions, especially in the Base programmes segment of the budget, combined with unexpected cost increases in some offices arising from large currency movements. The combination of these two factors created financial constraints and meant that areas of the budget, particularly in the regions, were not as well financed as had been planned, and were, therefore, unable to achieve their target implementation, while at the same time costs increased disproportionately at headquarters.

17. Exchange rates had a particularly severe impact in Switzerland, where, at its highest point in 2011, the value of the Swiss Franc exceeded average costs in 2009 by more than 40%, causing an equivalent increase in the cost of salaries and some programme and operating costs in headquarters for the month in question. Despite serious cost-cutting efforts and a reduction in staff, overall expenditure in headquarters remained higher in proportion to other offices than planned.

18. The Secretariat responded to the changes in the financial situation in various ways: a realistic Programme budget 2012–2013 was developed based on forecasts of income and expenditure; headquarters underwent a strategic programmatic and financing review in which staffing levels were reduced; some high-volume administrative functions in Geneva were reassigned to Kuala Lumpur; some staff numbers were also cut in other offices, particularly in the African Region; many cost-cutting efforts, including changes in travel policies, were implemented; and attention was focused on the reform agenda, including management and financing reforms. In addition, in 2011, at the programme level, prioritization and selective implementation of activities took place, referred to in many of the strategic objective summaries. The following tables show how the Programme budget

2010–2011 was financed and implemented to 31 December 2011, by budget segment, strategic objective and major office.

Table 2. Programme budget 2010–2011, financial implementation, by budget segment (US$ million, as at 31 December 2011)

Segment	Approved Programme budget 2010–2011	Funds available as at 31 December 2011			Funds available as % of approved Programme budget	Expenditure as at 31 December 2011	Expenditure as % of approved Programme budget	Expenditure as % of funds available
		Assessed contributions	Voluntary contributions	Total				
Base programmes	3 368	*934*	*1 537*	*2 472*	73%	2 221	66%	90%
Special programmes and collaborative arrangements	822	*4*	*1 312*	*1 315*	160%	1 108	135%	84%
Outbreak and crisis response	350	*1*	*456*	*457*	131%	388	111%	85%
Total*	**4 540**	***939***	***3 305***	***4 244***	**93%**	**3 717**	**82%**	**88%**
Encumbrances						149		
Budget utilization						3 866		

* Note: The total of US$ 3717 million in the column for expenditure as at 31 December 2011 excludes expenditures relating to in-kind and in-service contributions for Programme budget 2010–2011 of US$ 483 million. With the inclusion of these contributions, expenditure was US$ 4199 million (as shown in Schedule 2 of the Audited Financial Report). In addition to the expenditure shown above, US$ 149 million in encumbrances were incurred as firm commitments with suppliers. Including encumbrances, the total budget utilization was US$ 3866 million (before adding in-kind and in-service expenditures).

19. WHO's approved Programme budget for 2010–2011 was US$ 4540 million, of which US$ 944 million was to be financed from assessed contributions, and the balance of US$ 3600 million was to be financed by voluntary contributions.

20. The total funds available and planned for the biennium were US$ 4240 million or 93% of the approved budget. This was composed of income received in 2010–2011 from assessed and voluntary contributions of US$ 2800 million (excluding in-kind contributions), as well as income from 2008–2009 planned for 2010–2011 of US$ 457 million, and funds carried forward from 2008–2009 of US$ 943 million.

Table 3. Financing of the approved programme budgets 2010–2011 and 2012–2013 (US$ million)

	For Programme budget 2010–2011	For Programme budget 2012–2013
Income unimplemented in 2008–2009	943	
Income received in 2008–2009 and planned for 2010–2011	457	
Income received in 2010–2011 (US$ 3.8 billion)	2 844	1 000
Total	**4 244**	

21. The total expenditure was US$ 3.72 billion, or 82% of the approved programme budget (excluding in-kind contributions). The expenditure in relation to funds available was 88%. In addition, US$ 149 million in encumbrances was incurred for firm commitments to suppliers for goods and services. Including encumbrances, the budget utilization was US$ 3.86 billion.

22. While the level of financing for the total budget almost reached the budget target, financing was not evenly distributed across all segments of the budget, affecting levels of implementation by major office, strategic objective and budget segment.

23. In-kind (including in-service) expenditures of US$ 483 million were incurred in 2010–2011. Over 80% of the in-kind expenditures were for the receipt and distribution of H1N1 vaccines, which was recorded in the Outbreak and crisis response segment of the budget, almost entirely under headquarters. This unusually high level of in-kind contributions has had the effect of artificially increasing the funding for (primarily) strategic objective 1, Outbreak and crisis response in headquarters. In view of the fact that voluntary in-kind contributions are recorded as being equal amounts of both revenue and expenses, this analysis mainly considers the funding profile without the inclusion of in-kind contributions.[1]

24. WHO's approved Programme budget 2010–2011 total of US$ 4540 million is divided into segments, consisting of US$ 3368 million for Base programmes (74% of the Programme budget), US$ 822 million (18% of the Programme budget) for Special programmes and collaborative arrangements and US$ 350 million (8% of the Programme budget) for Outbreak and crisis response.

25. In 2010–2011, WHO improved its ability to track financing and expenditure according to the three budget segments, and the tables presented in this document provide a management analysis of the budget from this perspective. The three segments offer a useful lens through which to view the budget, in particular to understand the reasons for different levels of financing for different areas of the approved budget. There is also considerable collaboration across the budget areas, with funding from Special programmes and collaborative arrangements occasionally supporting activities under Base programmes, and funding in the Outbreak and crisis response area sometimes supporting activities that relate both to crisis response and preparedness.

[1] See also document A65/29, paragraph 10.

26. Funds available for the Base programmes segment of the budget were US$ 2.5 billion, or 73% of the budget requirements. The Special programmes and collaborative arrangements segment was financed to a level of 160% of the approved budget, and the Outbreak and crisis response segment was financed to a level of 131% of the approved budget. Differences in the sources and drivers of financing in the three budget areas account for the differences in the levels of financing.

27. The financing for the Special programmes and collaborative arrangements segment is frequently influenced by work with partners in various types of collaborative arrangements, for activities that meet WHO's objectives and yet may be driven by factors beyond the Organization's immediate control. Financing above the approved budget in the Special programmes and collaborative arrangements segment is seen mainly in two areas: poliomyelitis eradiation under strategic objective 1, and, to a lesser degree, where GAVI Alliance support was provided; and, under strategic objective 2, after the Global Fund to Fight AIDS, Tuberculosis and Malaria was recognized as a collaborative arrangement in early 2011. In addition, under strategic objective 11, recognition of WHO's work on prequalification of medicines and vaccines as a collaborative arrangement during 2010–2011 both increased financing levels and attracted new financing into the budget.

28. Financing for the Outbreak and crisis response segment of the budget is mainly driven by emergencies and outbreaks, which are, by their nature, unpredictable. The budget for these areas is approved at a minimal level at the beginning of the biennium, and then financing is made available in response to circumstances as they arise. Financing received above the approved budget in Outbreak and crisis response was mainly related to pandemic (H1N1) under strategic objective 1, although in the Eastern Mediterranean Region, significant increases in financing were also recorded under strategic objective 5 for activities related to the civil unrest of the "Arab Spring" in Egypt, Libya, the Syrian Arab Republic and Yemen, as well as to flooding in Pakistan. In the Region of the Americas, increases in Outbreak and crisis response funding under strategic objective 5 stemmed primarily from WHO's response to the earthquake in Haiti, and to flooding in the Philippines in the Western Pacific Region.

Table 4. Programme budget 2010–2011, financial implementation, by strategic objective, all segments (US$ million, as at 31 December 2011)

Strategic objective	**Approved Programme budget 2010–2011**	**Funds available as at 31 December 2011**			**Funds available as % of approved Programme budget**	**Expenditure as at 31 December 2011**	**Expenditure as % of approved Programme budget**	**Expenditure as % of funds available**
		Assessed contributions	Voluntary contributions	Total				
SO1	1 268	*72*	*1 400*	*1 472*	116%	1 290	102%	88%
SO2	634	*42*	*494*	*535*	84%	446	70%	83%
SO3	146	*38*	*74*	*112*	77%	98	67%	87%
SO4	333	*50*	*172*	*222*	67%	190	57%	86%
SO5	364	*16*	*377*	*393*	108%	312	86%	80%
SO6	162	*31*	*78*	*109*	67%	94	58%	86%
SO7	63	*16*	*26*	*42*	67%	37	59%	88%
SO8	114	*31*	*63*	*94*	82%	83	73%	88%
SO9	120	*18*	*51*	*70*	58%	62	52%	89%
SO10	474	*125*	*223*	*348*	73%	298	63%	86%
SO11	115	*27*	*131*	*158*	137%	137	119%	87%
SO12	223	*198*	*71*	*269*	121%	264	119%	98%
SO13	524	*276*	*144*	*420*	80%	405	77%	97%
Total	**4 540**	***939***	***3 305***	***4 244***	**93%**	**3 717**	**82%**	**88%**

Table 5. Programme budget 2010–2011, financial implementation, by strategic objective, Base programmes (US$ million, as at 31 December 2011)

Strategic objective	Approved Programme budget 2010–2011	Funds available as at 31 December 2011			Funds available as % of approved Programme budget	Expenditure as at 31 December 2011	Expenditure as % of approved Programme budget	Expenditure as % of funds available
		Assessed contributions	Voluntary contributions	Total				
SO1	542	*70*	*310*	*380*	70%	355	66%	93%
SO2	556	*40*	*314*	*354*	64%	294	53%	83%
SO3	146	*38*	*73*	*111*	76%	96	66%	86%
SO4	292	*49*	*124*	*172*	59%	149	51%	86%
SO5	109	*15*	*50*	*65*	59%	47	43%	72%
SO6	149	*31*	*63*	*94*	63%	81	54%	86%
SO7	63	*16*	*26*	*42*	66%	37	58%	88%
SO8	113	*31*	*62*	*93*	82%	82	73%	88%
SO9	116	*18*	*46*	*64*	55%	58	49%	90%
SO10	420	*125*	*161*	*286*	68%	250	59%	87%
SO11	115	*27*	*94*	*121*	105%	103	90%	86%
SO12	223	*198*	*71*	*269*	121%	264	119%	98%
SO13	524	*276*	*144*	*420*	80%	405	77%	97%
Total	**3 368**	***934***	***1 537***	***2 472***	**73%**	**2 221**	**66%**	**90%**

29. Financing below the level of the approved budget in Base programmes was notable across all technical strategic objectives, particularly 2, 4, 5, 9 and 10. Most of these particular strategic objectives are also areas of the programme budget with strategic aspiration in the regions, and in most cases this level of ambition was not met with a commensurate level of financing. Expenditure in relation to the approved budget was low in these areas in relation to the approved budget, while expenditure in relation to financing was much higher, generally between 85% and 90%.

30. Strategic objective 11 achieved the highest level of implementation in relation to the approved budget at 120%, due to the increase in prequalification activities for medicines, recognized as a collaborative arrangement in the Special programmes and collaborative arrangements segment of the budget after its approval.

31. During 2010–2011, several adjustments were made under strategic objectives 12 and 13 to better harmonize the planning of expenditures in country offices with the two strategic objectives. As a result, strategic objective 13 shows under-implementation against the original approved budget, and strategic objective 12 shows over-implementation. However, taken together, implementation was at 91% of the approved budget. This net under-implementation is in part due to budget reductions in

strategic objective 13 in order to effect a transfer outside the programme budget where funding was made available through the post occupancy charge (see summary table 6, page 84 of the 2010–2011 Programme budget). Through the mechanism of the post occupancy charge, direct costs for administration of programmes were charged to all strategic objectives in the Programme Budget. This amounted to an additional US$ 139 million for the administration of contracts, security, information technology infrastructure, and staff development, in addition to the costs of SO13 shown under the programme budget.

32. Under strategic objective 1, implementation in relation to the approved budget was 102% due to the elevated levels of implementation for certain elements in both Outbreak and crisis response (mainly for H1N1 vaccines) and Special programmes and collaborative arrangements (mainly for poliomyelitis eradication and support from the GAVI Alliance). In Base programmes, implementation of strategic objective 1 was 68% of the approved budget, or 91% of available financing. In addition, in headquarters, strategic objective 1 accounted for most of the in-kind expenditures recorded for H1N1 vaccines, more than US$ 400 million.

33. In all segments, the lowest levels of implementation occurred under strategic objectives 4, 6, 7 and 9, where implementation against the approved budget was 60% or less, due to lower than budgeted levels of financing. In all four cases, the Base programmes budget in 2010–2011 was increased to reflect the level of priority of these areas. However, financing was not sufficient to support the increased budget level, and only in SO9 was implementation significantly higher than in 2008–2009.

Table 6. Programme budget 2010–2011, financial implementation by major office, all segments (US$ million, as at 31 December 2011)

Location	**Approved Programme budget 2010–2011**	**Funds available as at 31 December 2011**			**Funds available as % of approved Programme budget**	**Expenditure as at 31 December 2011**	**Expenditure as % of approved Programme budget**	**Expenditure as % of funds available**
		Assessed contributions	Voluntary contributions	Total				
African Region	1 263	*209*	*931*	*1 139*	90%	1 026	81%	90%
Region of the Americas	256	*80*	*78*	*158*	62%	154	60%	97%
South-East Asia Region	545	*102*	*267*	*369*	68%	314	58%	85%
European Region	262	*62*	*161*	*223*	85%	199	76%	89%
Eastern Mediterranean Region	515	*90*	*477*	*567*	110%	449	87%	79%
Western Pacific Region	310	*78*	*194*	*272*	88%	251	81%	92%
Headquarters	1 389	*318*	*1 179*	*1 498*	108%	1 324	95%	88%
Total	**4 540**	***939***	***3 305***	***4 244****	**93%**	**3 717**	**82%**	**88%**

* Includes US$ 19 million of voluntary contributions not yet distributed to the major offices.

Table 7. Programme budget 2010–2011, financial implementation by major office, Base programmes (US$ million, as at 31 December 2011)

Location	Approved Programme budget 2010–2011	Funds available as at 31 December 2011			Funds available as % of approved Programme budget	Expenditure as at 31 December 2011	Expenditure as % of approved Programme budget	Expenditure as % of funds available
		Assessed contributions	Voluntary contributions	Total				
African Region	926	*209*	*316*	*524*	57%	478	52%	91%
Region of the Americas	245	*80*	*40*	*121*	49%	118	48%	98%
South-East Asia Region	394	*101*	*143*	*244*	62%	210	53%	86%
European Region	239	*62*	*128*	*190*	80%	170	71%	90%
Eastern Mediterranean Region	391	*90*	*139*	*229*	58%	176	45%	77%
Western Pacific Region	293	*78*	*166*	*244*	83%	224	77%	92%
Headquarters	881	*315*	*604*	*919*	104%	844	96%	92%
Total	**3 368**	***934***	***1 537***	***2 471****	**73%**	**2 221**	**66%**	**90%**

* Includes US$ 1 million of voluntary contributions not yet distributed to the major offices.

34. By major office, financing varied according to budget segment, and was also influenced by the impact on the various offices of the fall of the dollar. The heaviest cost increases were experienced in headquarters, as a result of the rise of the Swiss franc. This can be seen in the Base programmes segment, which bears the bulk of salary costs. In Base programmes, headquarters implementation was at 96% of the approved budget, owing to salary cost increases, while in all other regions, implementation varied between 45% and 77% of the approved budget, being mainly dependent on financing levels. The 2010–2011 Programme budget anticipated high levels of growth in implementation in all regions, in particular, in the African Region and the Region of the Americas. These expectations were not met by commensurate levels of financing.

35. In Special programmes and collaborative arrangements, expenditure varied between 86% and 382% of the approved budget in the regions, due mainly to increases in poliomyelitis eradication efforts; by comparison, in headquarters, budget implementation by Special programmes and collaborative arrangements was only 108% of the budget. Of the increase in financing above the approved budget, 94% was for the regions and 6% for headquarters. Most of the financing for Special programmes and collaborative arrangements above the expected budget level was to support poliomyelitis eradication and vaccination activities with the GAVI Alliance under strategic objective 1,

as well as support provided by the Global Fund to Fight AIDS, Tuberculosis and Malaria, for strategic objective 2.

36. Under Outbreak and crisis response, increases in financing can also mainly be attributed to implementation in the regions, which accounted for 64% of the financing above the level of the Programme budget.

ACHIEVEMENTS OF STRATEGIC OBJECTIVES AND ORGANIZATION-WIDE EXPECTED RESULTS

37. The remainder of the report provides a summary assessment for each strategic objective covering:

- overall progress made by Member States towards achievement of the results of each strategic objective;
- main achievement of the WHO Secretariat;
- assessment of Organization-wide expected results, including reasons for results "partly achieved".

38. These summary reports were prepared on the basis of comprehensive reports submitted by the 13 strategic objective teams. A full report is also available; it provides further details, particularly of the achievement of results at country level, key deliverables, and the priority areas designated for technical support during the biennium. Most importantly, it captures how the work relates to the indicators laid down in the Medium-term strategic plan 2008–2013.

STRATEGIC OBJECTIVE 1

To reduce the health, social and economic burden of communicable diseases

39. Communicable diseases are one of the greatest potential barriers to global health. Excluding HIV/AIDS, tuberculosis and malaria, they account for 20% of deaths in all age groups, 50% of child deaths and 33% of deaths in the least-developed countries. While progress continues to be made towards the prevention, surveillance and control of communicable diseases, there have been some major challenges in carrying out surveillance and response, enhancing research capacity, and developing, validating and making available new knowledge, intervention tools and strategies.

OWER 1.1

Policy and technical support provided to Member States in order to maximize equitable access of all people to vaccines of assured quality, including new immunization products and technologies, and to integrate other essential child-health interventions with immunization.

Partly achieved

Indicator	Baseline	Target	Achieved
1.1.1 Number of Member States with at least 90% national vaccination coverage (DTP3).	126	135	130
1.1.2 Number of Member States that have introduced *Haemophilus influenzae* type b vaccine in their national immunization schedule.	136	160	169

40. Extending immunization coverage to more children was a key achievement during the biennium. An estimated 109.4 million children under one year old were vaccinated with three doses of diphtheria-tetanus-pertussis vaccine, compared to 106 million in 2008. The number of countries reaching 90% or more immunization coverage with diphtheria-tetanus-pertussis vaccine rose to 130 countries compared to 120 in the previous biennium. An increase in uptake of new and underused vaccines was achieved. Pneumococcal and rotavirus vaccines were introduced in 55 and 28 countries respectively. Pneumococcal and rotavirus together are responsible for half the deaths from vaccine-preventable diseases of children under five years, and current and future progress is expected to contribute greatly to reducing overall child mortality. *Haemophilus influenza* type B (Hib) vaccine had been introduced in 169 countries by the end of 2010, compared to 136 in 2008.

41. During 2011, the first meningococcal A conjugate vaccine developed specifically for countries in the African "meningitis belt" was introduced. Over 54 million people received the vaccine during the campaigns. Six months after the introduction of the new vaccine, countries reported the lowest number of confirmed meningitis A cases recorded during an epidemic season.

42. The WHO Secretariat continued to support Member States through convening Ministry of Health immunization specialists and other partners to identify innovative ways to strengthen immunization services in countries through several platforms, including the Global Measles Management and the New Vaccines global meetings, which are held annually.

43. Despite good results this Organization-wide expected result was assessed as being partly achieved owing to only 130 Member States out of the targeted 135 having reported at least 90% national coverage with diphtheria-tetanus-pertussis vaccine. The results reflect weak health infrastructures; lack of community ownership of immunization programmes; difficulty in increasing routine immunization coverage in large countries; and the security situation in several countries, in particular in the African Region, Eastern Mediterranean Region and the South-East Asia Regions.

OWER 1.2

Effective coordination and support provided in order to achieve certification of poliomyelitis eradication, and destruction, or appropriate containment, of polioviruses, leading to a simultaneous cessation of oral poliomyelitis vaccination globally.

Partly achieved

Indicator		Baseline	Target	Achieved
1.2.1	Percentage of final country reports demonstrating interruption of wild poliovirus transmission and containment of wild poliovirus stocks accepted by the relevant regional commission for the certification of poliomyelitis eradication	87% for transmission interruption; 81% for containment	90%	80%
1.2.2	Percentage of Member States using trivalent oral poliovirus vaccine that have a timeline and strategy for eventually stopping its use in routine immunization programmes	0%	50%	0%

44. This biennium has been particularly challenging for the Global Polio Eradication Initiative. Towards the end of 2011, among the four countries with endemic transmission of wild poliovirus, namely Afghanistan, India, Nigeria and Pakistan, only India was on track to meet its end-2011 milestone for stopping virus circulation. Nigeria saw a threefold increase in cases of poliomyelitis in 2011 compared to 2010. Between 2010 and 2011, Afghanistan and Pakistan experienced a 135% and a 22% increase in cases, respectively. At the same time, progress was made towards poliomyelitis eradication. The year 2011 saw a 98% reduction in the number of cases reported in India (just one case), compared to 2010 (41 cases), and a reduction of more than 52% in cases globally.

45. WHO has coordinated the global roll-out and scale up of the new bivalent oral polio vaccine, which led to the success in stopping transmission in India. As one of the major actors of the Global Polio Eradication Initiative, WHO has also supported a full research agenda on accelerating eradication, to eliminate vaccine-derived polio vaccines and research to secure eradication. The Secretariat also fulfilled its role of processing analysis and distributing of information on the global poliomyelitis situation.

46. This Organization-wide expected result was only partly achieved despite significant progress in India, a reduction of global cases in 2011 and the rapid and effective response to new outbreaks. Ongoing transmission in priority countries, especially Nigeria and Pakistan, continues to threaten global eradication. Only 80% (instead of the 90% targeted) of the final country reports show interruption of wild poliovirus transmission and the acceptance of containment of wild poliovirus stocks by the relevant regional commission for the certification of poliomyelitis eradication.

OWER 1.3

Effective coordination and support provided to Member States in order to provide access for all populations to interventions for the prevention, control, elimination and eradication of neglected tropical diseases, including zoonotic diseases.

Partly achieved

Indicator	Baseline	Target	Achieved
1.3.1 Number of Member States certified for eradication of dracunculiasis.	175	179	180
1.3.2 Number of Member States that have eliminated leprosy at subnational levels.	78	95	Not available
1.3.3 Number of reported cases of human African trypanosomiasis for all disease-endemic countries.	9 503	8 500	8 000
1.3.4 Number of Member States having achieved the recommended target coverage of population at risk of lymphatic filariasis, schistosomiasis and soil-transmitted helminthiases through regular anthelminthic preventive chemotherapy.	15	20	23

47. The vision of controlling, eliminating and eradicating neglected tropical diseases has gathered significant momentum over recent years. WHO has produced evidence to show that the burden caused by many of the 17 diseases that affect more than 1 billion people worldwide can be effectively controlled and, in many cases, eliminated or even eradicated.

48. In 2010, WHO published its first report on neglected tropical diseases *Working to overcome the global impact of neglected tropical diseases*. The report, which is an important advocacy and strategy document, facilitated external support and regional action for stepping up preventive chemotherapy coverage in order to combat neglected tropical diseases in targeted countries, and elicited greater commitment to improving access to medicines, including through increased pharmaceutical donations. Most targeted countries have developed neglected tropical diseases master plans, which will enhance their capacity to mobilize and integrate the required resources and strengthen their ability to control neglected tropical diseases programmes. By the end of 2011, 180 Member States had been certified for eradication of dracunculiasis and 23 Member States had achieved the recommended target coverage of population at risk of lymphatic filariasis, schistosomiasis and soil-transmitted helminthiases through regular anthelminthic preventive chemotherapy.

49. Despite considerable progress, this Organization-wide expected result was considered to be partly achieved as the reporting on the elimination of leprosy at subnational level was incomplete as at the time of reporting.

OWER 1.4

Policy and technical support provided to Member States in order to enhance their capacity to carry out surveillance and monitoring of all communicable diseases of public health importance.

Fully achieved

Indicator	Baseline	Target	Achieved
1.4.1 Number of Member States with surveillance systems and training for all communicable diseases of public health importance for the country.	85	150	150
1.4.2 Number of Member States for which WHO/UNICEF joint reporting forms on immunization surveillance and monitoring are received on time at global level in accordance with established timelines.	148	150	151

50. There has been an improvement in the surveillance and monitoring of communicable diseases with 150 Member States reporting communicable diseases of public health importance. An improvement was also noted in the reporting of annual immunization with 190 (99%) Member States reporting data in 2011. WHO and UNICEF jointly reviewed all available information and produced immunization coverage estimates for all 193 Member States. This analysis included a refined method for developing coverage estimates to make them more transparent and reproducible. In addition, all levels of the Organization contributed to building national surveillance networks through the development of tools, guidelines and training programmes.

OWER 1.5

New knowledge, intervention tools and strategies that meet priority needs for the prevention and control of communicable diseases developed and validated, with scientists from developing countries increasingly taking the lead in this research.

Fully achieved

Indicator	Baseline	Target	Achieved
1.5.1 Number of new and improved tools or implementation strategies, developed with significant contribution from WHO, introduced by the public sector in at least one developing country.	6	9	17
1.5.2 Proportion of peer-reviewed publications based on WHO-supported research where the main author's institution is in a developing country.	>55%	55%	71%

51. Progress has been made in regions and countries on a variety of new intervention tools and strategies, with new knowledge being disseminated by institutions in developing countries through sustained support from the WHO Secretariat. For example, a best practice guidance framework document was developed, supported and tested in countries in order to support decision-making in countries on trials and use of genetically modified mosquitoes; tools such as qPCR as a biomarker of Chagas disease cure were standardized and validated; and a simplified system for dengue case classification was developed and evaluated in 18 countries, then adopted and widely used in

Latin America, and, increasingly, in Asia. A conjugated meningococcal A vaccine, targeted at the control of epidemic meningitis in Africa, was licensed and WHO-prequalified. The vaccine was developed by the Meningitis Vaccine Project, a partnership between WHO and PATH, and has been successfully introduced in several countries of the meningitis belt (Burkina Faso, Mali, Niger), reaching very high levels of coverage. In collaboration with partners, typhoid vaccine introduction strategies have been developed.

52. Capacity building through fostering developing countries' leadership in fighting neglected diseases of poverty and in vaccine development has continued. From 2010 to 2011, a number of small grants have supported in-country research studies, with some of those studies being published in peer-reviewed journals. A majority of publications' first author's institutions are from developing countries. Progress made in building countries' capacity included the establishment of a training and technology transfer hub for vaccine adjuvants and provision of training and technology to two developing countries. Regional training centres for training local researchers and research managers in good research practices have been established in institutions of four WHO regions, with support from WHO headquarters. The establishment of the African Network for Drugs and Diagnostics Innovation (ANDI), which became a legal entity in October 2010, represents an innovative approach to innovation in drugs and diagnostics.

OWER 1.6

Support provided to Member States in order to achieve the minimum core capacities required by the International Health Regulations (2005) for the establishment and strengthening of alert and response systems for use in epidemics and other public health emergencies of international concern.

Partly achieved

Indicator		Baseline	Target	Achieved
1.6.1	Number of Member States that have completed the assessment and developed a national action plan to achieve core capacities for surveillance and response in line with their obligations under the International Health Regulations (2005).	At least 95	115[a]	129
1.6.2	Number of Member States whose national laboratory system is engaged in at least one external quality-control programme for epidemic-prone communicable diseases.	140	120[b]	121

[a] The 2011 target for indicator 1.6.1 was revised to reflect latest estimates in line with the new monitoring system introduced in 2010.

[b] The 2011 target for indicator 1.6.2 was revised to reflect latest estimates in line with the new monitoring system introduced in 2010.

53. One of the main challenges WHO faced this biennium, is achieving the core capacities required by the International Health Regulations (2005) for the establishment and strengthening of alert and response systems for epidemics and other public health emergencies of international concern. A comparison of the status of International Health Regulations (2005) core capacities in countries reporting in 2010 and 2011 shows overall progress across all core capacities. The most noticeable progress was in surveillance and preparedness. There is also evidence that countries have made use of the different phases of pandemic (H1N1) 2009 in assessing the functioning of the International Health

Regulations, as well as in strengthening their technical capacities, including in laboratories. Human resource capacity at designated points of entry and for chemical events detection and response remains low.

54. A new monitoring system was introduced in 2010 that is currently used by Member States. It shows that the 2010 baseline figures were overestimated. The 2011 targets were revised to reflect the actual situation globally. Individual country data submitted through the system are confidential.

55. For this Organization-wide expected result, although both indicators have been achieved, the regions of the Americas, the European and the South-East Asia region, were only able to partly achieve the results, owing to difficulties in assessing and developing national core capacities under the International Health Regulations (2005).

OWER 1.7

Member States and the international community equipped to detect, assess, respond to and cope with major epidemic and pandemic-prone diseases (e.g. influenza, meningitis, yellow fever, haemorrhagic fevers, plague and smallpox) through the development and implementation of tools, methodologies, practices, networks and partnerships for prevention, detection, preparedness and intervention.

Partly achieved

Indicator		Baseline	Target	Achieved
1.7.1	Number of Member States having national preparedness plans and standard operating procedures in place for readiness and response to major epidemic-prone diseases.	139	165	158
1.7.2	Number of international coordination mechanisms for supplying essential vaccines, medicines and equipment for use in mass interventions against major epidemic and pandemic-prone diseases.	8	8	8
1.7.3	Number of severe emerging or re-emerging diseases for which prevention, surveillance and control strategies have been developed.	8	8	8

56. WHO supported ongoing reviews and revisions of preparedness plans and standard operating procedures based on pandemic lessons learnt. WHO also continued to support international and regional specialist networks, including the Global Influenza Surveillance Network, networks for infection control and the Emerging and Dangerous Pathogens Laboratory Network. In addition, emergency response teams were established at national and subregional levels. WHO issued new technical guidelines, including for surveillance and response to respiratory diseases, influenza surveillance, and clinical management of dengue cases.

57. Although this Organization-wide expected result was on track at the midpoint of the biennium, it was only partly achieved by the end of the biennium, as only 158 of the 165 Member States targeted had national preparedness plans and standard operating procedures in place for readiness and response to major epidemic-prone diseases. Obstacles to achievement included Member States' limited capacity for, and in some cases political commitment to, timely international or intersectoral collaboration, as

well as shortages of human, financial and logistical resources to implement strategies, especially for integrated vector control.

OWER 1.8

Regional and global capacity coordinated and made rapidly available to Member States for detection, verification, risk assessment and response to epidemics and other public health emergencies of international concern.

Fully achieved

Indicator	Baseline	Target	Achieved
1.8.1 Number of WHO locations with the global event-management system in place to support coordination of risk assessment, communications and field operations for headquarters, regional and country offices.	74	90	129

58. All six WHO regional offices are now using the WHO Event Management System[1] (EMS) in 129 geographical sites with the involvement of 169 teams and 597 users. WHO has responded to all Member States' requests for emergency support under the International Health Regulations (2005) by means of technical resources at headquarters, diverse specialist networks and the Global Outbreak Alert and Response Network. WHO's field response to major events and outbreaks has included the cholera outbreaks in Haiti and Pakistan and providing field missions in the aftermath of the Pakistan floods, which resulted in outbreaks of vectorborne illnesses, such as Crimean Congo haemorrhagic fever and dengue. Operational reviews of Global Outbreak Alert and Response Network missions were completed for the dengue outbreaks in Pakistan and for the cholera event in Haiti.

OWER 1.9

Effective operations and response by Member States and the international community to declared emergency situations due to epidemic- and pandemic-prone diseases.

Fully achieved

Indicator	Baseline	Target	Achieved
1.9.1 Proportion of Member States' requests for support that have led to effective and timely interventions by WHO, delivered using a global team approach, in order to prevent, contain and control epidemic and other public health emergencies.	n/a	99%	99%

59. WHO continued to provide support to the Emergency Committee until pandemic (H1N1) 2009 was declared to be over. It also provided material and evidence for evaluation by the Review

[1] WHO has developed a comprehensive "event management system" to manage critical information about outbreaks and ensure accurate and timely communications between key international public health professionals, including WHO Regional Offices, Country Offices, collaborating centres and partners in the Global Outbreak Alert and Response Network.

Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009. The Committee's final report was presented to the Sixty-fourth World Health Assembly.[1] One of its conclusions was that countries should scale up implementation of the International Health Regulations (2005).

STRATEGIC OBJECTIVE 2

To combat HIV/AIDS, tuberculosis and malaria

60. Progress against HIV/AIDS, tuberculosis and malaria is essential for the attainment of Millennium Development Goals 4, 5 and 6. During the biennium, advances were made in the adoption of effective policies and expansion of access to interventions, but significant challenges remain across all diseases, including demand for technical support in adopting new policies, and safely and effectively scaling them up.

61. Progress has continued in extending HIV-related services. The global incidence of HIV infection has stabilized and begun to decline in many countries with generalized epidemics, and an estimated 2.5 million lives have been saved since 1995. The number of people falling ill with tuberculosis has been declining since 2006, tuberculosis mortality has fallen by 40% since 1990, and an estimated additional 7 million lives have been saved since 1995. There have been remarkable gains in the scale-up of malaria control measures. During 2010 and 2011 in the African Region, about 220 million insecticide-treated mosquito nets were distributed and 78 million people were protected through indoor residual spraying of insecticide.

62. Despite substantial progress, the achievement of the global targets for HIV, tuberculosis and malaria prevention, treatment, and care is in danger. Of particular concern during the biennium were the increased rates of HIV infection in Eastern Europe and Central Asia, and the slow pace of multidrug-resistant tuberculosis treatment scale-up worldwide and of a decline in tuberculosis mortality in Africa. Coverage of key malaria prevention and treatment measures remains below target in most of the highest burden countries, and resistance to insecticides and antimalarial agents is a major concern.

OWER 2.1

Guidelines, policy, strategy and other tools developed for prevention of, and treatment and care for patients with, HIV/AIDS, tuberculosis and malaria, including innovative approaches for increasing coverage of the interventions among poor people, and hard-to-reach and vulnerable populations.

[1] Document A64/10.

Partly achieved

Indicator		Baseline	Target	Achieved
2.1.1	Number of low- and middle-income countries that have achieved 80% coverage for (a) antiretroviral therapy and (b) the prevention of mother-to-child transmission services.	Not available	(a) 15 and (b) 20	(a) 8 and (b) 13
2.1.2	Proportion of disease-endemic countries that have achieved their national intervention targets for malaria.	35%	60%	50%
2.1.3	Number of Member States that have achieved the targets of at least 70% case detection and 85% treatment success rate for tuberculosis.	42	46	45
2.1.4	Number of countries among the 27 priority countries with a high burden of multidrug-resistant tuberculosis that have detected and initiated treatment under the WHO-recommended programmatic management approach, for at least 70% of the estimated cases of multidrug-resistant tuberculosis.	2	4	5
2.1.5	Proportion of high-burden Member States that have achieved the target of 70% of persons with sexually transmitted infections diagnosed, treated and counselled at primary point-of-care sites.	Not available	70%	Not available

63. During the biennium, 10 countries had attained universal access (that is, coverage of at least 80% of the population in need) to antiretroviral therapy, and 13 had attained universal access to interventions for the prevention of mother-to-child transmission. The number of people receiving antiretroviral therapy had increased to 6.65 million, representing 47% of the 14.2 million people eligible for treatment. Almost 50% of pregnant women living with HIV received effective retroviral regimens to prevent mother-to-child transmission, and 17 countries reported testing over 90% of pregnant women for syphilis.

64. The Global health sector strategy on HIV/AIDS, 2011–2015 was endorsed by the Sixty-fourth World Health Assembly and disseminated during the biennium. Regional strategies were then adopted. In addition, new guidance was prepared, including on antiretroviral therapy for adults and children, prevention of mother-to-child transmission, infant feeding and updated tuberculosis/HIV guidance. Regional strategies for dual elimination of mother-to-child transmission of HIV and syphilis were launched or endorsed by Member States in three regions.

65. Overall, 46 million people have been successfully treated for tuberculosis since 1995 through the DOTS approach and the Stop TB Strategy. In addition, an estimated 910 000 lives have been saved between 2006 and 2010 through tuberculosis/HIV joint interventions recommended by WHO.

66. The Organization provided policy guidance for use of a rapid molecular test for tuberculosis and multidrug-resistant tuberculosis. By late 2011, 47 countries were using this technology. During the biennium, WHO led the development of the updated Global Plan to Stop TB 2011–2015 and regional strategies; issued new multidrug-resistant tuberculosis treatment guidelines, special reports on multidrug-resistant tuberculosis response and a regional multidrug-resistant tuberculosis plan in Europe, where the majority of most affected countries are; and guided population-based tuberculosis prevalence surveys in high-burden countries.

67. For malaria, a total of 43 countries reported a 50% or higher reduction in the number of cases and deaths since 2000, and three countries, Armenia, Morocco and Turkmenistan, were certified to be free of malaria during 2010 and 2011.

68. The WHO Global Malaria Programme defined its five-year strategy on the basis of four core functions and published new guidelines on the treatment of malaria and good procurement practices for artemisinin-based combination therapies and rapid diagnostic tests. WHO also developed, with 100 stakeholders, a global plan for artemisinin resistance containment and produced a major report on the status of drug resistance. In 2010, a new policy recommendation was issued on universal diagnostic testing of suspected malaria prior to treatment with either quality microscopy or a rapid diagnostic test.

69. Organization-wide expected result 2.1 relates to the implementation of WHO policies and not just their development and adoption. Overall, WHO met the objectives for its normative and strategic work at global level and in most regions however there were still challenges for countries in achieving implementation scale-up based on recommended policies based on resource and capacity constraints, such as for multidrug-resistant tuberculosis treatment, the timely initiation of antiretroviral treatment, adoption of some malaria prevention measures in high-burden countries, and measurement of treatment for sexually-transmitted infections.

70. The African Region, Eastern Mediterranean Region, South-East Asia Region and the Region of the Americas have reported their contributions as being partly achieved. In addition, data for the indicator on "proportion of high burden Member States that have achieved the target of 70% of persons with sexually transmitted infections diagnosed, treated and counselled at primary point-of-care sites" are only available from the European Region, South East Asia Region and Western Pacific Region, but not other regions, due to resource constraints on surveillance of sexually transmitted infections in regions and countries. Indicator measurement criteria, definitions and capacity will be further discussed in 2012–2013.

71. Due to the reasons mentioned above, the overall rating for this Organization-wide expected result is partly achieved.

OWER 2.2

Policy and technical support provided to countries towards expanded gender-sensitive delivery of prevention, treatments and care interventions for HIV/AIDS, tuberculosis and malaria, including integrated training and service delivery; wider service provider networks; and strengthened laboratory capacities and better linkages with other health services such as those for sexual and reproductive health, maternal, newborn and child health, sexually transmitted infections, nutrition, drug-dependence treatment services, respiratory care, neglected diseases and environmental health.

Partly achieved

Indicator	Baseline	Target	Achieved
2.2.1 Number of targeted Member States with comprehensive policies and medium-term plans in response to HIV, tuberculosis and malaria.	HIV: 103/131 tuberculosis: 90/95 malaria: 70/70	HIV: 115/131 tuberculosis: 118/118 malaria: 70/70	HIV: 158 tuberculosis: 119 malaria: 92

Indicator		Baseline	Target	Achieved
2.2.2	Proportion of high-burden countries monitoring provider-initiated HIV testing and counselling in sexually transmitted infection and family planning services.	55%	60%	Not available
2.2.3	Number of countries among the 63 with a high burden of HIV/AIDS and tuberculosis that are implementing the WHO 12-point policy package for collaborative activities against HIV/AIDS and tuberculosis.	18	30	43

72. The number of Member States with medium-term plans for the three diseases continued to grow, but they will need to be updated to reflect new WHO policies on diagnosis and treatment, although there has been relatively rapid adoption of policy guidance. WHO worked closely with other agencies, including the Global Fund to Fight AIDS, Tuberculosis and Malaria, UNAIDS, Roll Back Malaria, the Stop TB Partnership and bilateral agencies, in supporting the development of disease-specific plans and their integration in national health strategies and plans, and in coordinating the provision of technical support to Member States. Many countries moved during the period to adopt plans for the 2010–2015 period, together with use of the global plans and strategies for the three diseases.

73. The Organization-wide expected result saw significant progress in technical support and cooperation which was intensified in line with the demands of financing mechanisms and in order to accelerate implementation and measurement of impact. Nevertheless, the Organization-wide expected result was rated as partly achieved, due to the fact that data for indicator 2.2.2 on "proportion of high-burden countries monitoring provider-initiated HIV testing and counselling in sexually transmitted infection and family planning services" are available only from the Region of the Americas, the European Region, South East Asia Region and Western Pacific Region, mainly as a result of there being insufficient resources for sexually transmitted infection surveillance at the global, regional, and country level. In addition, the Eastern Mediterranean Region faced constraints during the latter half of the period, given security and other challenges.

OWER 2.3

Global guidance and technical support provided on policies and programmes in order to promote equitable access to essential medicines, diagnostic tools and health technologies of assured quality for the prevention and treatment of HIV/AIDS, tuberculosis and malaria, and their rational use by prescribers and consumers, and, in order to ensure uninterrupted supplies of diagnostics, safe blood and blood products, injections and other essential health technologies and commodities.

Partly achieved

Indicator		Baseline	Target	Achieved
2.3.1	Number of new or updated global norms and quality standards for medicines and diagnostic tools for HIV/AIDS, tuberculosis and malaria.	25	40	41

Indicator	Baseline	Target	Achieved
2.3.2 Number of priority medicines and diagnostic tools for HIV/AIDS, tuberculosis and malaria that have been assessed and prequalified for United Nations procurement.	226	300	300
2.3.3 Number of targeted countries receiving support to increase access to affordable essential medicines for HIV/AIDS, tuberculosis and malaria whose supply is integrated into national pharmaceutical systems (the number of targeted countries is determined for the six-year period).	HIV: 35 tuberculosis: 107 malaria: 43	HIV: 38 tuberculosis: 107 malaria:77	HIV: 73 tuberculosis: 111 malaria: 64
2.3.4 Number of Member States implementing quality-assured HIV/AIDS screening of all donated blood.	93	105	109
2.3.5 Number of Member States administering all medical injections using sterile single-use syringes.	183	180	180

74. Given a strong array of new medicines and diagnostics made available for HIV, tuberculosis and malaria response, WHO produced an important number of new guidelines for the safe and rapid adoption of these important new tools, enabling early detection and more effective treatment. WHO continued to respond well to the growing number of requests for support in assessing, prequalifying and gaining access to medicines and diagnostics in collaboration with the AIDS Medicines and Diagnostic Service, the Stop TB Partnership's Global Drug Facility, the Global Laboratory Initiative (secretariat in WHO), the Medicines for Malaria Venture, Roll Back Malaria, the Foundation for Innovative New Diagnostics and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

75. The Organization-wide expected result was partly achieved, and although there continues to be high productivity in endorsement and prequalification of HIV, tuberculosis and malaria medicines and diagnostics, solid support for supply systems in most regions, and high adoption of disposable syringes for injections, the African Region and Western Pacific Region have reported partial achievement due to ongoing capacity constraints enabling access and necessary support systems for these tools.

OWER 2.4

Global, regional and national systems for surveillance, evaluation and monitoring strengthened and expanded to keep track of progress towards targets and allocation of resources for HIV/AIDS, tuberculosis and malaria control and to determine the impact of control efforts and the evolution of drug resistance.

Partly achieved

Indicator	Baseline	Target	Achieved
2.4.1 Number of Member States providing WHO with annual data on surveillance, monitoring or financial allocation data for inclusion in the annual global reports on control of HIV/AIDS, tuberculosis or malaria and the achievement of targets.	HIV: 109 tuberculosis: 198 malaria: 107	HIV: 120 tuberculosis: 198 malaria: 107	HIV: 157 tuberculosis: 208[a] malaria: 105

Indicator		Baseline	Target	Achieved
2.4.2	Number of Member States reporting drug resistance surveillance data to WHO for HIV/AIDS, tuberculosis or malaria.	HIV: 54 tuberculosis: 114 malaria: 81	HIV: 65 tuberculosis: 125 malaria: 107	HIV: 61 tuberculosis: 127 malaria: 73

[a] The achievement figure for TB has referred since the beginning of the measurement of this indicator on Member States and other countries and territories.

76. In addition to the 2010 global reports on HIV/AIDS, TB and Malaria, 2011, saw the publication of the Progress report 2011: Global HIV/AIDS response reviews progress made until the end of 2010 in scaling up access to health sector interventions for HIV prevention, treatment, care and support in low–and middle-income countries; the progress report 2011, Global tuberculosis control: WHO report 2011 which is the sixteenth global report on tuberculosis (TB) published by WHO in a series that started in 1997. It provides a comprehensive and up-to-date assessment of the TB epidemic and progress in implementing and financing TB prevention, care and control at global, regional and country levels using data reported by 198 countries that account for over 99% of the world's TB cases and the World Malaria Report 2011 summarizes information received from 106 malaria-endemic countries and a range of other sources. It analyses prevention and control measures according to a comprehensive set of indicators, and highlights continued progress towards global malaria targets.

77. Overall, the Organization-wide expected result has seen an improvement in coverage of Member State reporting on epidemiological and programme performance measures. However, it has been partly achieved as expanded coverage in some areas of drug resistance surveillance has been slower than expected, including as reported in the Eastern Mediterranean and South-East Asia Regions.

OWER 2.5

Political commitment sustained and mobilization of resources ensured through advocacy and nurturing of partnerships on HIV/AIDS, tuberculosis and malaria at country, regional and global levels; support provided to countries as appropriate to develop or strengthen and implement mechanisms for resource mobilization and utilization and increase the absorption capacity of available resources; and engagement of communities and affected persons increased to maximize the reach and performance of HIV/AIDS, tuberculosis and malaria control programmes.

Fully achieved

Indicator		Baseline	Target	Achieved
2.5.1	Number of Member States with functional coordination mechanisms for HIV/AIDS, tuberculosis and malaria control.	HIV: 108 tuberculosis: 95 malaria: 77	HIV: 118 tuberculosis: 110 malaria: 70	HIV: 152 tuberculosis: 122 malaria: 72
2.5.2	Number of Member States involving communities, persons affected by the diseases, civil-society organizations and the private sector in planning, design, implementation and evaluation of HIV/AIDS, tuberculosis and malaria programmes.	HIV: at least 99 tuberculosis: 87 malaria: 77	HIV: 120 tuberculosis: 87 malaria: 70	HIV: 147 tuberculosis: 100 malaria: 76

78. WHO hosts the Stop TB Partnership, the International Drug Purchase Facility (UNITAID) and the Roll Back Malaria Partnership, and is a UNAIDS cosponsor and board member of the Global Fund to Fight AIDS, Tuberculosis and Malaria. It also reinforced its role in other collaborative arrangements, where, by doing so, it could improve support for Member States in achieving the targets set out in the Medium-term strategic plan 2008–2013, as well as the health-related Millennium Development Goals. WHO continued to build the capacity of those applying for Global Fund grants, including national disease-control programmes. As a result, financing was made available for increasing universal access to services as well as for surveillance, monitoring, evaluation, and impact measurement. A reduction in financial and human resources during the second half of the biennium means that WHO is having to adjust its priorities with regard to partnerships. Member States and WHO at country level have continued to engage with a widening array of affected persons, communities, civil society and private sector partners.

79. The Organization-wide expected result was fully achieved as work on building partnerships and resource mobilization capacity at country, regional and global levels has met expectations and expanded in line with major new opportunities at country and global level.

OWER 2.6

New knowledge, intervention tools and strategies developed and validated to meet priority needs for the prevention and control of HIV/AIDS, tuberculosis and malaria, with scientists from developing countries increasingly taking the lead in this research.

Partly achieved

Indicator	Baseline	Target	Achieved
2.6.1 Number of new and improved tools or implementation strategies for HIV/AIDS, tuberculosis or malaria implemented by the public sector in at least one developing country.	1	6	17
2.6.2 Proportion of peer-reviewed publications arising from WHO-supported research on HIV/AIDS, tuberculosis or malaria and for which the main author's institution is based in a developing country.	71%	55%	61%

80. In general, increased support for research and knowledge management led to the development and adoption of new disease prevention and control strategies, and the number of new and improved tools implemented surpassed the initial targets. WHO and the Special Programme for Research and Training in Tropical Diseases, with numerous partners, published evidence-based results of country-based clinical, epidemiological and operational research.

81. This Organization-wide expected result has contributed to new policies and strategies adopted during the biennium, however, the African Region and the South-East Asia Region reported significant constraints on research capacity in countries.

STRATEGIC OBJECTIVE 3

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

82. Noncommunicable diseases – mainly cardiovascular diseases, cancers, chronic respiratory diseases and diabetes – are the greatest cause of death worldwide. More than 36 million people each year die from such causes (63% of global deaths), including 9 million people who die prematurely, before the age of 60. Together with mental disorders, violence and injuries, the combined causes are responsible for 75% of all deaths – a figure that is projected to increase over the next 10 years. In addition, 15% of the global population lives with a disability as a result of which their full participation in society may be impeded. The increasing burden will be borne mainly by low- and middle-income countries.

OWER 3.1

Advocacy and support provided to increase political, financial and technical commitment in Member States in order to tackle chronic noncommunicable diseases, mental and behavioural disorders, violence, injuries and disabilities together with visual impairment, including blindness.

Fully achieved

Indicator		Baseline	Target	Achieved
3.1.1	Number of Member States whose health ministries have a focal point or a unit for injuries and violence prevention with its own budget.	156	162	164
3.1.2	The world report on disability and rehabilitation published and launched, in response to resolution WHA58.23.	Draft report prepared	Report published in 6 languages	Report published in 6 languages
3.1.3	Number of Member States with a mental health budget of more than 1% of the total health budget.	90	100	100
3.1.4	Number of Member States with a unit in the ministry of health or equivalent national health authority, with dedicated staff and budget, for the prevention and control of chronic noncommunicable diseases.	75	122	165

83. With the support of multiple partners, WHO has advocated for an increased commitment to, and action on, noncommunicable diseases. This has resulted in several global agreements during the biennium, including the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases (United Nations General Assembly resolution 66/2). The commitment of Member States was also evidenced by several other high-level resolutions, including resolution WHA63.13 on the global strategy to reduce the harmful use of alcohol and United Nations General Assembly resolution 64/255 declaring a Decade of Action

for Road Safety 2011–2020. Greater awareness was also evident at national level from an increase from 122 to 165 in the number of Member States with administrative units focused on the prevention and control of noncommunicable diseases.

OWER 3.2

Guidance and support provided to Member States for the development and implementation of policies, strategies and regulations in respect of chronic noncommunicable diseases, mental and neurological disorders, violence, injuries and disabilities together with visual impairment, including blindness.

Partly achieved

Indicator		Baseline	Target	Achieved
3.2.1	Number of Member States that have national plans to prevent unintentional injuries or violence.	83	88	133
3.2.2	Number of Member States that have initiated the process of developing a mental health policy or law.	51	56	56
3.2.3	Number of Member States that have adopted a multisectoral national policy on chronic noncommunicable diseases.	75	90	121
3.2.4	Number of Member States that are implementing comprehensive national plans for the prevention of hearing or visual impairment.	88	100	59

84. WHO continues to play a pivotal role in providing guidance on the development, implementation and monitoring of policies and programmes for prevention, management and rehabilitation of noncommunicable diseases, mental and behavioural disorders, violence, injuries and disabilities. In all technical areas there was a substantial increase in the number of countries with relevant policies, legislation, action plans, and national budgets building the groundwork for subsequent implementation and scaling-up of effective interventions. The number of Member States with national plans for preventing unintentional injuries or violence increased from 83 to 133. Progress continues to be made in the area of noncommunicable diseases with the number of Member States that have adopted a multisectoral national policy on chronic diseases rising from 75 to 121. The number of countries with mental health policies, plans and laws increased from 51 to 56. It is also noted that the quality of action plans in all technical areas increased significantly. A clear challenge is that, due to the nature of these technical areas, a broad response implemented by various sectors is required.

85. At the regional level, regional and country offices strengthened their capacity to provide direct technical support to Member States to enable them to adapt and adopt policy guidelines and evidence-based best practices. However, this Organization-wide expected result was assessed to be “partly achieved” as the number of Member States implementing comprehensive national plans for the prevention of hearing or visual impairment did not meet the expected target. This was mainly due to the strengthening of the measurement criteria used to assess this indicator.

OWER 3.3

Improvements made in Member States' capacity to collect, analyse, disseminate and use data on the magnitude, causes and consequences of chronic noncommunicable diseases, mental and neurological disorders, violence, injuries and disabilities together with visual impairment, including blindness.

Partly achieved

Indicator		Baseline	Target	Achieved
3.3.1	Number of Member States that have submitted a complete assessment of their national road traffic injury prevention status to WHO during the biennium.	175	175	175
3.3.2	Number of Member States that have a published document containing national data on the prevalence and incidence of disabilities.	158	163	193
3.3.3	Number of low- and middle-income Member States with basic mental health indicators annually reported.	98	110	110
3.3.4	Number of Member States with a national health reporting system and annual reports that include indicators for the four major noncommunicable diseases.	116	136	101
3.3.5	Number of Member States documenting, according to population-based surveys, the burden of hearing or visual impairment.	34	38	47

86. The collection, analysis and use of data on the magnitude, causes and consequences of noncommunicable diseases are vital for targeting, preventing and evaluating progress. Overall, Member States have continued to improve their capacity to collect and analyse information in the areas of mental health, road traffic injury prevention and the burden of hearing or visual impairment. In particular the number of Member States that have a published document containing national data on the prevalence and incidence of disability has increased from 158 to 193. This represents the most comprehensive list of national disability prevalence estimates currently available, and contributed to a number of major reports issued during the biennium, including the *World report on disability* and the *Report on mental health and development: targeting people with mental health conditions as a vulnerable group*. In addition, several key reports monitoring progress around the world, such as the first *Global status report on noncommunicable diseases 2010*, the *Mental health atlas 2011* and the *Global status report on road safety*, were published.

87. While significant progress has been made in most areas, this Organization-wide expected result was assessed to be "partly achieved" as the number of Member States with a national health reporting system and annual reports that include indicators for the four major noncommunicable diseases did not meet the expected target number of 136. This was mainly due to further refinements of the criteria and methods used for measuring this indicator, which required Member States to report on these indicators in the past five years. While in fact a number of countries included the required indicators in their routine reporting systems, reports dating back less than five years were not always available, which

led to a reduced number of Member States being assessed as meeting the more stringent criteria and the original target not being met.

OWER 3.4

Improved evidence compiled by WHO on the cost-effectiveness of interventions to tackle chronic noncommunicable diseases, mental and neurological and substance-use disorders, violence, injuries and disabilities together with visual impairment, including blindness.

Fully achieved

Indicator		Baseline	Target	Achieved
3.4.1	Availability of evidence-based guidance on the effectiveness of interventions for the management of selected mental, behavioural or neurological disorders including those due to use of psychoactive substances.	8 interventions published and disseminated	12 interventions published and disseminated	12 interventions published and disseminated
3.4.2	Availability of evidence-based guidance or guidelines on the effectiveness or cost-effectiveness of interventions for the prevention and management of chronic noncommunicable diseases.	4 interventions published and disseminated	5 interventions published and disseminated	6 interventions published and disseminated

88. The *mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings* was launched during the biennium. Drawing on a comprehensive review of the existing evidence, it provides recommendations to facilitate high-quality care at first- and second-level facilities by non-specialist health-care providers. The guide quickly became a well-known and frequently used resource. To date it has been implemented in eight countries, including countries with large populations, such as India and Thailand. A significant number of nongovernmental organizations and private organizations base their interventions on the guidance. It has been made available in the six WHO official languages, and in addition has been made available in Hindi, Portuguese and Thai.

89. Evidence-based guidance was developed for selected essential noncommunicable disease interventions for primary health care in resource-constrained settings. Building on guidance developed earlier on applicable and feasible interventions, the focus during this biennium was placed on cost-effective interventions, so-called “best-buys”, which are likely to yield a high impact, and are at the same time feasible for rapid scale-up in low-resource settings.

OWER 3.5

Guidance and support provided to Member States for the preparation and implementation of multisectoral, population-wide programmes to promote mental health and to prevent mental and behavioural disorders, violence and injuries, together with hearing and visual impairment, including blindness.

Partly achieved

Indicator		Baseline	Target	Achieved
3.5.1	Number of guidelines published and widely disseminated on multisectoral interventions to prevent violence and unintentional injuries.	10	14	15
3.5.2	Number of Member States that have initiated community-based projects during the biennium to reduce suicides.	17	21	21
3.5.3	Number of Member States implementing strategies recommended by WHO for the prevention of hearing or visual impairment.	88	100	78

90. The target number of 14 violence and injury prevention guidelines published and widely disseminated was fully achieved. The Secretariat published 15 guidelines, which included six on road traffic injury prevention; five on violence prevention, two on crosscutting topics, and one each on child injury prevention and burn prevention. Several new guidelines were published and widely disseminated. These included *Preventing intimate partner and sexual violence against women: taking action and generating evidence*, *Burns prevention: success stories and lessons learned*, and *Mobile phone use: a growing problem of driver distraction*. In addition to direct country support, capacity building for violence and injury prevention included the launch of a series of interactive Webinars and TEACH-VIP E-Learning, a comprehensive curriculum for self-paced, self-administered training online. Community-based projects to prevent suicides have been initiated in 21 Member States.

91. While progress has been made in most areas, this Organization-wide expected result was assessed to be "partly achieved" as the number of Member States implementing strategies recommended by WHO for the prevention of hearing or visual impairment did not meet the expected target. A detailed review in 2011 revealed that the initial target was too ambitious, so both the baseline and the target were reduced by about 30%. This was mainly due to further refinements of the criteria and methods used for measuring this indicator that led to a reduced number of Member States being assessed as meeting the more stringent criteria, and the original target not being met.

OWER 3.6

Guidance and support provided to Member States to improve the ability of their health and social systems to prevent and manage chronic noncommunicable diseases, mental and behavioural disorders, violence, injuries and disabilities together with visual impairment, including blindness.

Fully achieved

Indicator		Baseline	Target	Achieved
3.6.1	Number of Member States that have incorporated trauma-care services for victims of injuries or violence into their health-care systems using WHO trauma-care guidelines.	22	27	70
3.6.2	Number of Member States implementing community-based rehabilitation programmes.	29	34	34

Indicator		Baseline	Target	Achieved
3.6.3	Number of low- and middle-income Member States that have completed an assessment of their mental health systems using the WHO Assessment Instrument for Mental Health Systems (WHO-AIMS).	72	80	80
3.6.4	Number of low- and middle-income Member States implementing primary health-care strategies for screening of cardiovascular risk and integrated management of noncommunicable diseases using WHO guidelines.	51	26[a]	36
3.6.5	Number of Member States with tobacco cessation support incorporated into primary health care.	55	40	65

[a] The original baseline of 51 was arrived at before the availability of survey data. Based on the global capacity assessment survey, which provided more reliable data, the target was revised to 26.

92. Services for pre-hospital and hospital based care for the injured have been incorporated in 70 Member States, a fact that is largely attributable to WHO's efforts to develop trauma-care guidance. Such efforts were undertaken to address the burden of the injured in the country and often also as a part of broader health system strengthening plans. The *WHO Guidelines on community-based rehabilitation* were developed in collaboration with a large number of Member States, and have been field tested in 29 countries, followed by regional launches in Asia, Europe and Latin America. The Secretariat provided specific support to community-based rehabilitation programmes in 34 countries and established regional community-based rehabilitation networks covering 86 countries in three regions. Eight additional countries have completed an assessment of their mental health systems in the past biennium, resulting in 78 country reports now being available on the WHO web site for mental health evidence and research.

93. Thirty-six countries in all regions are adopting integrated primary health-care strategies for screening of cardiovascular risk and integrated management of noncommunicable diseases using WHO guidance. A few have developed plans for national scale-up. Some countries have begun to include essential noncommunicable disease interventions in basic health care packages and also to explore innovative mechanisms to finance them. There has been major progress in providing tobacco cessation support in primary health care in countries during the biennium. According to the WHO *Report on the global tobacco epidemic, 2011*, 65 Member States provide tobacco-cessation support in primary health care, and provide at least some cost coverage for tobacco-dependence treatment.

STRATEGIC OBJECTIVE 4

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

94. Action was significantly accelerated in the political arena towards attainment of Millennium Development Goals 4 (Reduce child mortality) and 5 (Improve maternal health). The launching of the United Nations Secretary-General's Global Strategy for Women's and Children's Health in 2010 and the related Commission on Information and Accountability in 2011 underlined the high-level political

commitment and created additional momentum towards reaching these goals. The Countdown to 2015 also tracks progress towards achievement of the two Millennium Development Goals and WHO serves on its coordinating committee.

95. Although there has been a significant reduction in maternal deaths, the rate of decline is less than half of what is necessary to achieve Millennium Development Goal 5. Nearly 50% of all child deaths occur in the African Region, which also has the highest maternal mortality ratio in the world. Globally, most under-five deaths are still from pneumonia, diarrhoea, malaria, malnutrition and neonatal conditions. Newborn mortality has declined more slowly than child mortality and progress is very uneven among regions.

96. Throughout the biennium there has been an increased emphasis on partnership. Commitments made by G8 countries at the 2010 meeting in Muskoka, Canada resulted in significant financial commitments that group together the work of United Nations partners including WHO, UNICEF, UNFPA, World Bank, UNAIDS and UN Women.

OWER 4.1

Support provided to Member States to formulate a comprehensive policy, plan and strategy for scaling up towards universal access to effective interventions in collaboration with other programmes, paying attention to reducing gender inequality and health inequities, providing a continuum of care throughout the life course, integrating service delivery across different levels of the health system and strengthening coordination with civil society and the private sector.

Fully achieved

Indicator		Baseline	Target	Achieved
4.1.1	Number of targeted Member States that have an integrated policy on universal access to effective interventions for improving maternal, newborn and child health.	20	40	72
4.1.2	Number of Member States that have developed, with WHO support, a policy on achieving universal access to sexual and reproductive health.	30	40	63

97. Universal access to reproductive, maternal, child and adolescent health services, as well as services to promote and support healthy ageing, remains a significant challenge, and the development of integrated policies is an essential step. The importance of integrated policies has been increasingly recognized, as the evidence ever more strongly supports the interrelationship between the health of mothers, neonates, children, and adolescents who then become parents. This integration is also incontrovertibly important from the point of view of programming and use of resources.

98. Although national health policies and strategies are moving towards integration, with technical support provided by WHO when requested, translating this integration into service delivery is complex and demanding. In line with the United Nations Secretary-General's Global Strategy for Women's and Children's Health in 2010, WHO placed particular emphasis on supporting policies for integrated service delivery across the life course; approaches to removing barriers to accessing such services; and methods for maintaining or improving the quality of the care provided. Seventy-two Member States have reported having integrated policies on access to maternal, newborn and child health, and 63 on

access to sexual and reproductive health. The majority of these policies were developed with the input and support of WHO.

OWER 4.2

National research capacity strengthened as necessary and new evidence, products, technologies, interventions and delivery approaches of global and/or national relevance available to improve maternal, newborn, child and adolescent health, to promote active and healthy ageing, and to improve sexual and reproductive health.

Fully achieved

Indicator		Baseline	Target	Achieved
4.2.1	Number of research centres that have received an initial grant for comprehensive institutional development and support.	8	8	12
4.2.2	Number of completed studies on priority issues that have been supported by WHO.	16	28	60
4.2.3	Number of new or updated systematic reviews on best practices, policies and standards of care for improving maternal, newborn, child and adolescent health, promoting active and healthy ageing or improving sexual and reproductive health.	20	40	89

99. Comprehensive institutional development and support, including through grants, contributed to strengthening research centres; at the end of the biennium 12 research centres had received such grants.

100. To define research priorities for maternal, newborn and child health, WHO and the Alliance for Health Policy and Systems Research convened 11 workshops in the African Region, Western Pacific Region and South-East Asia Region. One important outcome was the shift in emphasis from clinical research to operations research, aiming to improve delivery mechanisms for and resolve barriers in access to effective interventions.

101. WHO also supported research projects addressing regional and national reproductive health priorities. Research projects focused on violence against women, medical abortion and consequences of anaemia in pregnancy as well as on research methodology in sexual and reproductive health, research ethics and data analyses.

102. Overall the number of new or updated systematic reviews on best practices, policies and standards of care for improving maternal, newborn, child and adolescent health, promoting active and healthy ageing or improving sexual and reproductive health increased from 20 at the beginning of the biennium to 89 by the end of 2011.

OWER 4.3

Guidelines, approaches and tools for improving maternal care applied at the country level, including technical support provided to Member States for intensified action to ensure skilled care for every pregnant woman and every newborn, through childbirth and the postpartum and postnatal periods, particularly for poor and disadvantaged populations, with progress monitored.

Fully achieved

Indicator		Baseline	Target	Achieved
4.3.1	Number of Member States implementing strategies for increasing coverage with skilled care for childbirth.	25	50	66

103. Overall, the estimated annual number of maternal deaths worldwide has declined by 34% from 1990 to 2008. The annual rate of reduction of 2.3% in estimated maternal mortality ratios over the past two decades (1990–2008) remains well below 5.5%, the rate required to reach the relevant target of Millennium Development Goal 5.

104. In response to the United Nations Secretary-General's Global Strategy for Women's and Children's Health, more than 60 countries have made commitments towards improving women's and children's health. The number of Member States implementing strategies for increasing coverage with skilled care for childbirth increased from 25 in 2010 to 66 by the end of the biennium. Globally, the proportion of births attended by skilled health personnel increased from 58% to 68% between 1990 and 2008. Continuing armed conflicts in some countries continue to challenge efforts to reduce maternal mortality and morbidity.

105. The Regional Office for the Americas, together with headquarters and partners, developed a Plan of action to accelerate the reduction of maternal mortality and severe morbidity, which focuses on the improvement of health service quality of care and was unanimously approved by all health ministers in the Region.

106. Country-specific support has been provided to improve maternal health including introduction of the "Beyond the numbers" methodology on analysis of maternal mortality and morbidity, development and updates of national guidelines based on WHO Integrated Management of Pregnancy and Childbirth clinical guidelines, training, maternal mortality reviews estimating resource requirements, and programme reviews. The Campaign on accelerated reduction of maternal mortality was launched in 34 African countries.

107. Although Organization-wide expected result 4.3 is a priority area and effective tools are available, a lack of resources, including qualified staff and translated tools, has limited the technical support WHO can provide, especially in connection with improving the quality of care during childbirth and in the postnatal period in the African Region and South-East Asian Region.

OWER 4.4

Guidelines, approaches and tools for improving neonatal survival and health applied at country level, with technical support provided to Member States for intensified action towards universal coverage, effective interventions and monitoring of progress.

Fully achieved

Indicator		Baseline	Target	Achieved
4.4.1	Number of Member States implementing strategies for increasing coverage with interventions for neonatal survival and health.	40	50	56

108. Neonatal mortality rates are declining in all regions and fewer newborn infants are dying worldwide than ever before, but there are major regional variations, with the largest proportional relative increase in Europe, South-East Asia and the Western Pacific. In all regions, except Africa, newborn deaths represent more than 40% of all early childhood deaths. Given the close links of neonatal mortality and morbidity with the health of the mother and the care provided to her around birth, progress towards increased coverage of skilled care at birth needs to be taken into account in this context.

109. The Secretariat has provided technical support to countries to improve policies, planning and programme development for newborn health. The main focus has been in four areas: (1) an integrated approach to strengthen the neonatal health component within maternal and child health programmes, (2) the implementation of essential newborn care as part of Integrated Management of Pregnancy and Childbirth guidelines, (3) the promotion of Integrated Management of Childhood Illness with its newborn component, and (4) the promotion of Caring for the Newborn at Home.

110. With WHO support, the number of Member States implementing strategies for increasing coverage with interventions for neonatal survival and health have increased from 40 in 2010 to 56 at the end of the biennium.

OWER 4.5

Guidelines, approaches and tools for improving child health and development applied at the country level, with technical support provided to Member States for intensified action towards universal coverage of the population with effective interventions and for monitoring progress, taking into consideration international and human-rights norms and standards, notably those stipulated in the Convention on the Rights of the Child.

Fully achieved

Indicator		Baseline	Target	Achieved
4.5.1	Number of Member States implementing strategies for increasing coverage with child health and development interventions.	40	40	79
4.5.2	Number of Member States that have expanded coverage of the integrated management of childhood illness to more than 75% of target districts.	30	45	54

111. The Integrated Management of Childhood Illness strategy was expanded to include the newborn, and, in some regions, the healthy child. It remains the principal strategy for newborn and child health in all regions and has been widely adopted by partners; child mortality reached an historic

low of 7.6 million during the biennium. The African Region has doubled its average annual rate of reduction in under-five mortality from 1.2% per year over 1990–2000 to 2.4% per year over 2000–2010. Support has been provided to countries in all regions for developing or revising national strategies in order to improve the skills of health-care providers in newborn care (using WHO's Essential Newborn Care Course), and for care of the newborn at home.

112. The strategy has been introduced in the African Region, South-East Asia Region and Western Pacific Region. In addition, those regions as well as the Eastern Mediterranean Region, have introduced integrated care for sick children in the community through training lay community health workers to assess, provide treatment where possible, and refer cases. A total of 14 countries in the European Region embarked on systematic improvements in hospital paediatric care.

OWER 4.6

Technical support provided to Member States for the implementation of evidence-based policies and strategies on adolescent health and development, and for the scaling up of a package of prevention, treatment and care interventions in accordance with established standards.

Partly achieved

Indicator		Baseline	Target	Achieved
4.6.1	Number of Member States with a functioning adolescent health and development programme.	40	50	74

113. WHO has supported Member States to carry out national situation analyses and national programme reviews as well as develop strategic plans. As a result, the number of Member States with a functioning adolescent health and development programme has increased from 40 at the beginning of the biennium to 74 as at the end of 2011.

114. A systematic review of the prevention of early pregnancy was completed and guidelines on preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries were produced. Within the context of national multisectoral programmes, WHO supported the definition and strengthening of health service provision for adolescents through: developing national quality standards for adolescent-friendly health services; adapting training and monitoring tools; and supporting competency-based training and activities aimed at achieving national quality standards. The Regional Office of the Americas has placed particular emphasis on this age group at regional and country levels.

115. The Organization-wide expected result 4.6 has been partly achieved, as reported by the African Region, Eastern Mediterranean Region and South-East Asia Region as well as in headquarters, and was particularly affected in all major offices by a lack of financial and human resources for providing systematic technical support to countries, especially for strategic planning and adolescent-friendly health services.

OWER 4.7

Guidelines, approaches and tools made available, with provision of technical support to Member States for accelerated action towards implementing the strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health, with particular emphasis on ensuring equitable access to good-quality sexual and reproductive health services, particularly in areas of unmet need, and with respect for human rights as they relate to sexual and reproductive health.

Fully achieved

Indicator		Baseline	Target	Achieved
4.7.1	Number of Member States implementing the WHO reproductive health strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health agreed at the 1994 International Conference on Population and Development (ICPD), its five-year review (ICPD+5), the Millennium Summit and the United Nations General Assembly in 2007.	30	40	60
4.7.2	Number of targeted Member States having reviewed their existing national laws, regulations or policies relating to sexual and reproductive health.	8	12	20

116. Progress has been made in strengthening the capabilities of national experts in operational research in reproductive health, thereby contributing to the overall implementation of the reproductive health strategy. Coverage of family planning is key, as is the incorporation of effective existing or new interventions into practice through operations research.

117. The number of Member States implementing the WHO reproductive health strategy to accelerate progress towards the attainment of international development goals and targets has increased from 30 at the beginning of the biennium to 60 by the end of 2011. The Secretariat supported countries in incorporation of new evidence in policy and programmes and implementation of evidence-based interventions. Support was provided through updated norms and guidelines in various aspects of sexual and reproductive health including family planning (four cornerstones of family planning), maternal and perinatal health (haemorrhage and eclampsia guidelines), cervical cancer prevention, and prevention of unsafe abortion.

OWER 4.8

Guidelines, approaches, tools, and technical support provided to Member States for increased advocacy for consideration of ageing as a public health issue, for the development and implementation of policies and programmes aiming at maintaining maximum functional capacity throughout the life course and for the training of health-care providers in approaches that ensure healthy ageing.

Partly achieved

Indicator		Baseline	Target	Achieved
4.8.1	Number of Member States with a functioning active healthy ageing programme consistent with WHA58.16 "Strengthening active and healthy ageing".	15	20	33

118. There is growing recognition of healthy ageing as an important global challenge, as evidenced by the steadily increasing number of countries with functioning programmes. However, given the limited resources available in this area, cooperation with other stakeholders, such as the European Commission, is critical. The impact of the Organization's normative work, such as guidelines and frameworks for assessment, is greatest where there are existing bottom-up initiatives. An example of this is the age-friendly city network, where healthy ageing is promoted through improving the capacity of the health workforce.

119. Despite having made gradual progress, the area of ageing was assessed as partly achieved in the African Region and South-East Asia Region where there are inadequate financial and technical resources.

STRATEGIC OBJECTIVE 5

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

120. During the biennium, many Member States faced debilitating humanitarian emergencies, starting with the earthquake in Haiti in January 2010 that killed over 200 000 people and affected over 3 million others and was followed by a cholera outbreak; the earthquake in Chile; flooding in Pakistan that affected more than 20 million people; flooding in the Philippines; the earthquake and radiological event in Japan; the earthquake in Turkey; civil unrest in Egypt, Libya, Yemen and Syria, as well as in Côte d'Ivoire; famine and its health consequences in the Horn of Africa, which affected some 10 million people; and numerous smaller and less visible natural disasters and public health events.

121. Given the increasing frequency and life-threatening consequences of emergencies worldwide, the complexity of the work, and the increasing demands of Member States, WHO worked closely with numerous partners, including national authorities, civil society, United Nations agencies, existing and new donors and the private sector, to enhance emergency preparedness and response capacity in the health sector. Member States also identified emergency preparedness and response as a key area of cooperation with WHO; 119 Member States included this area in their country cooperation strategies.

122. During this biennium, four of the Organization-wide expected results for SO5 were considered to be fully achieved and three were partly achieved. These overall ratings were based on the level of achievement on the indicator targets as measured and reported by the major offices, using methods consistent with previous biennial performance reports. However, a qualitative analysis of WHO's work in emergency preparedness, response and recovery suggests that a more robust set of Organization-wide performance standards is required to measure achievements accurately. Without such criteria, most of these Organization-wide expected result (OWER) should be regarded as being only partly achieved, particularly in the light of the existing challenges.

123. To address the challenges that the Secretariat and Member States face in emergency risk management and humanitarian response, and to align with the developments of the WHO reform process and the IASC 2011 Transformative Agenda process, WHO undertook an extensive consultative process with internal and external stakeholders in the second half of the biennium. This was in order to refine and restructure its work in emergencies, resulting in (1) the development of a new, Organization-wide emergency response framework that includes measurable performance standards, (2) the restructuring, repurposing and 50% downsizing of the headquarters emergency department, (3) the streamlining of the SO5 expected results from seven to two: one for preparedness and one for response, and (4) a more realistic component of the SO5 part of the Programme budget for 2012–2013 with emphasis on strengthening regional and country level capacities. Moving into 2012, the Board and Health Assembly will be discussing WHO's role in emergencies, and its proposed emergency response framework, and providing further direction to WHO's work in this area.

OWER 5.1

Norms and standards developed, capacity built and technical support provided to Member States for the development and strengthening of national emergency preparedness plans and programmes.

Partly achieved

Indicator		Baseline	Target	Achieved
5.1.1	Proportion of Member States with national emergency preparedness plans that cover multiple hazards.	60%	65%	72%
5.1.2	Number of Member States implementing programmes for reducing the vulnerability of health facilities to the effects of natural disasters.	46	50	91

124. WHO supported Member States in reducing the physical and functional vulnerability of health systems and communities in order to ensure the continuity of health services following an event, and to increase the health sector preparedness of Member States.

125. WHO participated in the establishment of a Global Platform for Disaster Risk Reduction with the goal of improving implementation of disaster risk reduction through better communication and coordination among stakeholders. Regional offices have developed guidelines for disaster risk reduction as well as toolkits for evaluating health system capacity for crisis management. In addition, technical support was provided to implement country level emergency risk management programmes and to take action on resolution WHA64.10 on strengthening national health emergency and disaster management capacities and resilience of health systems. As a result, the percentage of Member States

implementing safe hospitals programmes rose from 23% to 46% during the biennium and the percentage of Member States with national emergency preparedness plans rose from 60% to 72%.

126. While the indicator targets have been achieved for this Organization-wide expected result, the Regional Office for Africa, the Regional Office for South-East Asia and the Regional Office for the Western Pacific, as well as headquarters, have reported partial achievement of their contribution to this Organization-wide expected result. The primary reasons were the lack of an Organizational framework to clarify and guide WHO's support to Member States in the area of emergency preparedness, lack of clear performance standards; and a lack of sustainable funding.

OWER 5.2

Norms and standards developed and capacity built to enable Member States to provide timely response to disasters associated with natural hazards and conflict-related crises.

Fully achieved

Indicator		Baseline	Target	Achieved
5.2.1	Operational platforms for surge capacity in place in regions and headquarters ready to be activated in acute-onset emergencies.	80%	100%	100%
5.2.2	Number of global and regional training programmes on public health operations in emergency response.	22	35	44

127. With the support of WHO, Member States continued to build their national capacities for emergency response in the health sector during the biennium. WHO led the collaborative work of the Global Health Cluster, which is made up of more than 30 international humanitarian health organizations in building response and recovery capacity. It also conducted 44 training courses on strengthening the response and recovery capacities of national counterparts, WHO staff and international partners; reinforced its operational platforms for rapid deployment of experts, funds and supplies at the regional and headquarters levels; developed key tools related to child health, mental health and post-disaster needs assessments; and influenced policy-making in the global humanitarian arena through active involvement in the work of the Inter-Agency Standing Committee.

128. Although this Organization-wide expected result was assessed as having been fully achieved, more work needs to be done to develop minimal institutional readiness standards and Organization-wide response systems and procedures. While mechanisms were put in place, they were unable to meet surge demands. This was particularly evident in 2011 when the Organization and partners were unable to meet Member State and partner demands for human resource surge capacities during major humanitarian emergencies. During the 2012–2013 biennium, particular attention will be given to addressing the ongoing challenge.

OWER 5.3

Norms and standards developed and capacity built to enable Member States to assess needs and for planning interventions during the transition and recovery phases of conflicts and disasters.

Partly achieved

Indicator		Baseline	Target	Achieved
5.3.1	Number of humanitarian action plans with a health component formulated for ongoing emergencies.	26	In all countries with humanitarian coordinators (39)	In all countries with humanitarian coordinators (39)
5.3.2	Number of countries in transition that have formulated a recovery strategy for health.	12	18	33

129. Progress was made by many Member States facing protracted emergencies in their positioning of health within the humanitarian action plan. Each of the 39 countries with a humanitarian coordinator developed a health component in the humanitarian action plan. Thirty-three countries developed health sector recovery strategies over the course of the biennium

130. WHO formulated a methodology for post-disaster and post-conflict needs assessment, in collaboration with relevant United Nations agencies, the World Bank and the European Union. Several regional offices have participated in the finalization of the post-conflict and post-disaster needs assessment tools for recovery planning. The Regional Office for the Western Pacific developed a post-disaster health needs and risk assessment tool to guide identification of the health needs of affected populations.

131. While the indicator targets have been achieved for this Organization-wide expected result, the African Region and the Eastern-Mediterranean Region, as well as headquarters, have reported partial achievement, mainly due to the lack of a consistent Organizational approach and guidance to affected countries, as well as inadequate post-crisis donor support.

OWER 5.4

Coordinated technical support provided to Member States for communicable disease control in natural disaster and conflict situations.

Fully achieved

Indicator		Baseline	Target	Achieved
5.4.1	Proportion of acute natural disasters or conflicts where communicable disease-control interventions have been implemented, including activation of early-warning systems and disease-surveillance for emergencies.	100%	100%	100%

132. Member States are leading efforts to conduct surveillance, to prevent and to control communicable diseases during conflicts and natural disasters in all WHO regions.

133. A Communicable Disease Working Group on Emergencies was established to provide technical support for communicable disease control in humanitarian emergencies to Member States, regional,

country offices and partners. Six public health risk assessment documents were produced following the earthquake in Haiti, crises in Kyrgyzstan and Uzbekistan, floods in Pakistan, unrest in Libya, famine in the Horn of Africa and the earthquake in Turkey. Another six communicable disease epidemiological profiles were developed for Afghanistan, the Central African Republic, Chad, Cote d'Ivoire, Sri Lanka and Zimbabwe.

134. All acute natural disasters or conflicts where communicable disease-control interventions have been implemented were successfully addressed, including activation of early-warning systems and disease-surveillance for emergencies. WHO will make further efforts to ensure that contingency plans will integrate crisis management of epidemics and stronger collaboration with national communicable disease surveillance programmes, laboratories and pharmacies within and outside the health sector. Health needs and risks assessments in case of disasters and conflicts need to integrate communicable disease risks and better benefit from International Health Regulations (2005) risk assessment capabilities.

OWER 5.5

Support provided to Member States for strengthening national preparedness and for establishing alert and response mechanisms for food-safety and environmental health emergencies.

Partly achieved

Indicator		Baseline	Target	Achieved
5.5.1	Proportion of Member States with national plans for preparedness, and alert and response activities in respect of chemical, radiological and environmental health emergencies.	60%	65%	70%
5.5.2	Number of Member States with focal points for the International Food Safety Authorities Network and for the environmental health emergencies network.	173	In all Member States	177

135. Environmental health was a key component of many crises faced by Member States during the biennium, from the earthquake in Haiti to the flooding in Pakistan, to the mass lead poisoning in Nigeria.

136. Technical support was provided to Member States for strengthening national preparedness, alert and response mechanisms in respect of chemical, radiological and environmental health. As a result the proportion of Member States with specific preparedness plans for chemical, radiological and environmental health emergencies increased from 60% to 70%. In addition, 91% of Member States have national focal points for the International Food Safety Authorities Network, up from 89% two years ago.

137. While the indicator targets have been achieved for this Organization-wide expected result, the African Region, Eastern Mediterranean Region, South-East Asia Region and Western Pacific Region have reported partial achievement, the limitation being mainly due to concern regarding the lack of experts covering this area.

OWER 5.6

Effective communications issued, partnerships formed and coordination developed with other organizations in the United Nations system, governments, local and international nongovernmental organizations, academic institutions and professional associations at the country, regional and global levels.

Partly achieved

Indicator		Baseline	Target	Achieved
5.6.1	Proportion of Member States affected by acute-onset emergencies and those with ongoing emergencies and a humanitarian coordinator in which the Inter-Agency Standing Committee Humanitarian Health Cluster is operational in line with IASC cluster standards.	60%	80%	>80%
5.6.2	Proportion of Member States with ongoing emergencies and a humanitarian coordinator having a sustainable WHO technical presence covering emergency preparedness, response and recovery.	60%	75%	>75%

138. Building on global and country level partnerships, WHO served as lead agency of the health cluster in all countries implementing the cluster approach. In all these countries, WHO supported Member States by coordinating the work of the humanitarian health community in accordance with the health sector plan. However, in some countries, significant concerns were expressed by partners and stakeholders that cluster leadership functions were not fully delivered. Without standard criteria for measuring performance in this area, these indicators are therefore marked as not fully reached and thus the expected result as only partly achieved. Challenges to achieving this expected result include the lack of a harmonized Organization-wide approach, a lack of skills in coordination, information collection and management and strategic planning, the lack of a strategy for coordinating large numbers of partners in mega-crises such as in Haiti, and the lack of funding for cluster leadership functions.

OWER 5.7

Acute, ongoing and recovery operations implemented in a timely and effective manner.

Fully achieved

Indicator		Baseline	Target	Achieved
5.7.1	Proportion of acute-onset emergencies for which WHO mobilizes coordinated national and international action.	80%	90%	90%
5.7.2	Proportion of interventions for chronic emergencies implemented in accordance with humanitarian action plans' health components.	100%	100%	100%

139. The Organization-wide expected result was fully achieved in consideration of the achievement of indicators but major challenges included the lack of an overall response framework, including measurable performance standards, response capacities, procedures and a robust system for monitoring and evaluation.

STRATEGIC OBJECTIVE 6

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

140. Noncommunicable diseases are the leading cause of death throughout the world, responsible for 63% of all deaths globally. Four behavioural risk factors – tobacco use, unhealthy diet, insufficient physical activity and the harmful use of alcohol – are responsible for raising the risk of noncommunicable diseases, in particular heart disease and stroke, diabetes, cancers, and chronic lung disease. The leading global risks for mortality in the world are high blood pressure (responsible for 13% of deaths globally), tobacco use (9%), high blood glucose (6%), physical inactivity (6%), and overweight and obesity (5%). Unsafe sex and alcohol use are also among the leading risks for burden of disease as measured in disability-adjusted life years (DALYs) – accounting for a combined 10% of global DALYs. Cumulative economic losses to low- and middle-income countries from noncommunicable diseases are estimated at US$ 500 billion per year, which is equivalent to 4% of their current annual output.

141. A key to addressing behavioural risk factors is mustering the political, financial and technical commitment to address noncommunicable diseases as a health and development issue. Member States made an important step forward in how to tackle noncommunicable diseases, in particular, by addressing the key risk factors, in agreements reached through the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases (United Nations General Assembly resolution 66/2). This commitment is further evidenced in the continuing support of the WHO Framework Convention on Tobacco Control and other resolutions such as WHA57.17 on the Global strategy on diet, physical activity and health, WHA63.14 on Marketing of food and non-alcoholic beverages to children; and WHA57.12 on Reproductive health: draft strategy to accelerate progress towards the attainment of international development goals and targets. Multisectoral action for health is central to all of these strategies.

OWER 6.1

Advice and support provided to Member States to build their capacity for health promotion across all relevant programmes, and to establish effective multisectoral and multidisciplinary collaborations for promoting health and preventing or reducing major risk factors.

Fully achieved

Indicator		Baseline	Target	Achieved
6.1.1	Number of Member States that have evaluated and reported on at least one of the action areas and commitments of the Global Conferences on Health Promotion.	31	40	120

Indicator		Baseline	Target	Achieved
6.1.2	Number of cities that have implemented healthy urbanization programmes aimed at reducing health inequities.	17	22	34

142. By the end of 2011, 120 Member States had evaluated and reported on at least one of the action areas and commitments of the Global Conferences on Health Promotion. The Urban Health Equity and Response Tool (Urban HEART) was applied in 34 cities in 23 countries in order to reduce health inequalities.

143. Although this Organization-wide expected result has been "fully achieved", the measurement of the number of Member States that have evaluated and reported on at least one of the action areas and commitments on the Global Conferences on Health Promotion has proved to have been too broadly defined. It measures a wide range of health promotion actions, such as development of strategies, plans and partnerships, which are to be assessed as part of the achievement, but does not necessarily pay attention to their effective implementation. The measurement criteria for this indicator will be reviewed and strengthened in 2012–2013.

OWER 6.2

Guidance and support provided in order to strengthen national systems for surveillance of major risk factors through development and validation of frameworks, tools and operating procedures and their dissemination to Member States where a high or increasing burden of death and disability is attributable to these risk factors.

Fully achieved

Indicator		Baseline	Target	Achieved
6.2.1	Number of Member States with a functioning national surveillance system for monitoring major risk factors to health among adults based on the WHO STEPwise approach to surveillance.	80	85	94
6.2.2	Number of Member States with a functioning national surveillance system for monitoring major risk factors to health among youth based on the Global school-based student health survey methodology.	52	58	72

144. The collection, analysis and use of data on risk factor exposure at country level is vital for targeting, preventing and evaluating progress. Member States have made progress in this area with a total of 94 Member States now using the WHO STEPwise approach to monitor the exposure of their adult populations to key noncommunicable diseases risk factors and 72 Member States are monitoring youth risk behaviours and protective factors using the WHO global school-based student health survey (GSHS).

145. There has also been an increase in the number of Member States conducting specific risk factor survey such as the Global Adult Tobacco Survey. In this biennium, WHO published the Global status report on noncommunicable diseases, which provides a comprehensive assessment of the current

status of the key risk factors in this strategic objective, as well as a set of guidelines for addressing noncommunicable diseases through comprehensive, intersectoral interventions.

OWER 6.3

Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed, and technical support provided to Member States with a high or increasing burden of disease and death associated with tobacco use, enabling them to strengthen institutions in order to tackle or prevent the public health problems concerned; support also provided to the Conference of the Parties to the WHO Framework Convention on Tobacco Control for implementation of the provisions of the Convention and development and implementation of protocols and guidelines.

Fully achieved

Indicator		Baseline	Target	Achieved
6.3.1	Number of Member States having comparable adult tobacco prevalence data available from recent national representative surveys, such as the Global Adult Tobacco Survey (GATS) or STEPS.	56	78	78
6.3.2	Number of Member States with comprehensive bans on smoking in indoor public places and workplaces.	20	29	31
6.3.3	Number of Member States with bans on tobacco advertising, promotion and sponsorship.	26	20	20

146. The WHO Framework Convention on Tobacco Control entered into force in 2005; in 2008 WHO introduced the MPOWER package of demand reduction measures to help countries fulfil some of their obligations under the Framework Convention. By the end of 2011, substantial progress had been made in applying demand reduction measures: 31 countries have enacted national-level smoke-free laws covering all public places and workplaces; 26 countries have total tobacco taxes amounting to more than the recommended minimum of 75% of the retail price; 19 countries now mandate best-practice health warning labels on cigarette packs; 20 countries have complete bans on all tobacco advertising, promotion and sponsorship. WHO conducted capacity assessments, developed training packages and provided technical support to 20 countries in implementing the demand reduction measures. WHO was a direct contributor to increasing the efficiency and effectiveness of tobacco tax systems in 12 Member States by directly engaging with finance ministries on tax issues and providing specialist training.

147. Refinements have been made to the measurement of the number of Member States with bans on tobacco advertising, promotion and sponsorship. A more stringent definition of banned tobacco advertising, promotion and sponsorship activities was introduced to be consistent with the definitions contained in the final approved guidelines on the WHO Framework Convention on Tobacco Control. As a result, the baseline 2010, target 2011 and achievement value for 2011 were recalculated.

OWER 6.4

Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed, and technical support provided to Member States with a high or increasing burden of

disease or death associated with alcohol, drugs and other psychoactive substance use, enabling them to strengthen institutions in order to combat or prevent the public health problems concerned.

Fully achieved

Indicator		Baseline	Target	Achieved
6.4.1	Number of Member States that have developed, with WHO support, strategies, plans and programmes for combating or preventing public health problems caused by alcohol, drugs and other psychoactive substance use.	38	50	57
6.4.2	Number of WHO strategies, guidelines, standards and technical tools developed in order to provide support to Member States in preventing and reducing public health problems caused by alcohol, drugs and other psychoactive substance use.	11	14	16

148. The WHO Global strategy to reduce the harmful use of alcohol was endorsed by the Sixty-third World Health Assembly, prompting a growing number of countries to develop or revise national alcohol policies and action plans in line with the global strategy. A total of 57 countries now have national policies on alcohol and another 10 subnational alcohol policies. WHO developed several technical tools to support implementation of effective alcohol control policy options, including the guide on legislation provision for alcohol control and identification and management of alcohol use disorders in health-care settings.

OWER 6.5

Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed and technical support provided to Member States with a high or increasing burden of disease or death associated with unhealthy diets and physical inactivity, enabling them to strengthen institutions in order to combat or prevent the public health problems concerned.

Fully achieved

Indicator		Baseline	Target	Achieved
6.5.1	Number of Member States that have adopted multisectoral strategies and plans for healthy diets or physical activity, based on the WHO Global Strategy on Diet, Physical Activity and Health.	61	65	79
6.5.2	Number of WHO technical tools that provide support to Member States in promoting healthy diets or physical activity.	16	20	22

149. By the end of 2011, 79 Member States had adopted multisectoral strategies and plans for healthy diets or physical activity based on the Global Strategy on Diet, Physical Activity and Health. During the biennium, WHO developed an implementation guide to support Member States in

implementing the recommendations on the marketing of foods and non-alcoholic beverages, as had been approved in resolution WHA63.14. WHO also published a set of global recommendations on physical activity for health and has been working with Member States to implement them at a national level.

OWER 6.6

Evidence-based and ethical policies, strategies, interventions, recommendations, standards and guidelines developed and technical support provided to Member States to promote safer sex and strengthen institutions in order to tackle and manage the social and individual consequences of unsafe sex.

Partly achieved

Indicator		Baseline	Target	Achieved
6.6.1	Number of Member States generating evidence on the determinants and/or consequences of unsafe sex.	8	10	22
6.6.2	Number of Member States generating comparable data on unsafe sex indicators using WHO STEPS surveillance tools.	2	5	5

150. Under the WHO Global reproductive health strategy, 22 Member States generated evidence on the determinants and/or consequences of unsafe sex, and new and improved interventions to promote safer sexual behaviours were implemented in several countries. However, achievement of the indicators has been uneven across regions.

151. This Organization-wide expected result was assessed to be "partly achieved" because of limited progress in some regions, particularly the African Region and the Eastern Mediterranean Region, as a result of limitations in funding and prioritization.

STRATEGIC OBJECTIVE 7

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

152. Despite increasing global political attention, health inequities continue to grow within and between countries aggravated by rapid urbanization, man-made and natural disasters, economic recession, and unemployment. Tackling inequities in health is a major public health priority.

153. Member States increasingly seek innovative ways to foster intersectoral collaboration on the social and economic determinants of health and see the need to integrate equity-enhancing, pro-poor, gender-responsive and ethically sound approaches into their health sectors and social policies and programmes. Member States expressed their increased political commitment to this during the World

Conference on Social Determinants of Health, held in Rio de Janeiro, Brazil in October 2011.[1] As a result, the demand from Member States for support from WHO has increased sharply and 84 Member States requested technical support this biennium. These approaches have also been integrated into a number of disease-specific programmes across the Organization.

OWER 7.1

Significance of social and economic determinants of health recognized throughout the Organization and incorporated into normative work and technical collaboration with Member States and other partners.

Fully achieved

Indicator		Baseline	Target	Achieved
7.1.1	Number of WHO regions with a regional strategy for addressing social and economic determinants of health as identified in the Report of the Commission on the Social Determinants of Health endorsed by the Director-General	4	5	5

154. The World Conference on Social Determinants of Health provided a forum for enhancing the political visibility of intersectoral governance for health equity and for enabling technical exchange on what works. As part of the preparation of the meeting over 40 country case studies were documented, which captured the good practices at the country level on addressing social determinants of health.

155. The framework and findings of the Knowledge Networks of the Commission on Social Determinants of Health were used to support integration of Social determinants of health and health equity into national health plans and public health strategies in 9 countries. Six countries were supported to build leadership capacity of the Ministry of Health to coordinate and manage interventions seeking to reduce the equity gap by addressing social determinants of health.

OWER 7.2

Initiative taken by WHO in providing opportunities and means for intersectoral collaboration at national and international levels to address social and economic determinants of health, including understanding and acting upon the public health implications of trade and trade agreements, and to encourage poverty-reduction and sustainable development.

[1] The outcome of the Conference, the Rio Political Declaration on Social Determinants of Health was endorsed in resolution EB130.R11: Outcome of the World Conference on Social Determinants of Health. The resolution calls, inter alia, for better governance at global, regional, national and local levels. WHO is called upon to ensure that work on social determinants of health carried out by different United Nations agencies is better aligned and harmonized.

Fully achieved

Indicator		Baseline	Target	Achieved
7.2.1	Number of published country experiences on tackling social determinants for health equity.	10	14	28
7.2.2	Number of tools to support countries in analysing the implications of trade and trade agreements for health.	8	9	9

156. Countries are embarking on changes to their intersectoral governance practices to increase their impact on health equity, at both national and international levels. New public health legislation addressing health equity and health-in-all-policies has been introduced in some countries. At global and regional levels, WHO promoted the development of international consensus on the key elements of a health-in-all-policies approach through the Adelaide Statement on Health in All Policies and the Rio Political Declaration on Social Determinants of Health.

157. Globalization and trade have a major influence on health outcomes. During the biennium, WHO continued to support Member States in capacity building for assessing trade and its impact on health outcomes. Several publications, including books, briefing documents and fact-sheets were produced during the biennium. WHO has now established an active trilateral cooperation with WIPO and WTO at global level and the three organizations have started to organize a series of joint technical symposiums on issues covered by the Global strategy and plan of action on public health, innovation and intellectual property.

OWER 7.3

Social and economic data relevant to health collected, collated and analysed on a disaggregated basis (by sex, age, ethnicity, income, and health conditions, such as disease or disability).

Partly achieved

Indicator		Baseline	Target	Achieved
7.3.1	Number of country reports published during the biennium incorporating disaggregated data and analysis of health equity.	35	40	46

158. There has been some progress across regions in the use of disaggregated data to measure health inequities and their determinants. The number of country reports published during the biennium incorporating disaggregated data and analysis on health equity has increased from 35 to 46. An increasing number of countries have asked for support, tools and capacity building for improved measurement. In response to this demand, the Secretariat disseminated a template to regions for developing national health inequalities reports, provided technical support for the use of the existing health information system to identify priority social determinants of health areas for action and produced a publication on mainstreaming gender into emerging infectious disease programmes.

159. While overall the target of country reports published during the biennium incorporating disaggregated data and analysis of health equity was met, this Organization-wide expected result has been assessed as having been partly achieved. This is mainly due to the partial achievement of the result in the Eastern Mediterranean Region, where many countries have not yet institutionalized the

collection of disaggregated data, and in headquarters, where the monitoring of health inequities and the collection and use of disaggregated data is not sufficiently mainstreamed within WHO programmes nor consolidated through the global health observatory.

OWER 7.4

Ethics- and rights-based approaches to health promoted within WHO and at national and global levels.

Partly achieved

Indicator		Baseline	Target	Achieved
7.4.1	Number of tools produced for Member States or the Secretariat giving guidance on using a human rights-based approach to advance health.	28	37	37
7.4.2	Number of tools produced for Member States or the Secretariat giving guidance on use of ethical analysis to improve health policies.	12	16	16

160. WHO has a specific mandate to ensure that ethical analysis is included in health policies and programmes. Applying ethical standards is imperative for clinical trials and health research. In close collaboration with national ethics committees, WHO facilitated the Collaborating Centres for Bioethics and other international organizations active in the field to support the growth of synergies between different global initiatives. Following the adoption of resolution WHA63.22 on Human organ and tissue transplantation, a working group of national ethics committees was established to work on its implementation in countries. Guidance on ethical aspects of tuberculosis control was developed and disseminated in countries and technical support was provided to Member States to enable them to strengthen their ethics review systems, including clinical trial registration. The number of clinical trials registered in the International Clinical Trial Registry Platform database has grown by 50 557 to a total of 153 092 by the end of 2011.[1] It is vital that all clinical trials be registered in order to increase transparency for both researchers and users.

161. WHO has supported countries to review national health sector strategic plans in the light of their health-related human rights obligations and commitments, including the right to accessible and affordable health services, the right to participate in decision-making processes, and the right to redress through mechanisms of accountability.

162. The Organization-wide expected result was partly achieved as the European Region and the South-East Asia Region have reported partial achievement of their contributions. The main obstacles to achieving the Organization-wide expected result were a lack of capacity in identifying and addressing emerging priority issues, and the lack of capacity to respond to urgent requests from countries. In addition, the reporting process was significantly hampered by insufficient information on ethical activities implemented by countries in some regions.

[1] Numbers of average monthly hits on the ICTRP search portal (http://www.who.int/trialsearch) increased from 140 000 in 2009 to 2 100 000 in 2011. With this, the ICTRP is ranked number 3 on WHO's top ranking list, following classifications and the WHO media centre.

OWER 7.5

Gender analysis and responsive actions incorporated into WHO's normative work and support provided to Member States for formulation of gender-responsive policies and programmes.

Partly achieved

Indicator		Baseline	Target	Achieved
7.5.1	Number of WHO tools, documents (developed or updated) and joint activities with WHO technical units to promote gender responsive actions into the work of WHO.	63	85	98
7.5.2	Number of gender mainstreaming activities conducted in Member States supported by WHO.	142	170	189

163. In the area of Gender and health, important progress on mainstreaming gender within countries' policies and health interventions was observed notably in the African Region and in the Region of the Americas, in the latter of which gender mainstreaming collaboration plans were developed in 10 countries. The Secretariat has produced 98 guidance documents and tools and implemented joint activities with different technical areas including the Gender and primary care renewal and the Gender and human rights tool, besides producing various publications on the linkages between gender and gender-based violence and HIV. The Gender, Women and Health Network saw an increase in the number of gender focal points[1] to 112 in all WHO regions.

164. While the goals under Organization-wide expected result were generally met, the African Region and the European Region rated their contributions to this expected result as partly achieved. Performance towards the end of the biennium was hampered by staff shortages both at headquarters and in some regions, which directly affected support to Member States.

STRATEGIC OBJECTIVE 8

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

165. Environmental and occupational determinants of health are responsible for about a quarter of the global burden of disease and an estimated 13 million deaths each year. Those most affected are poor women and children who live and work in the world's most polluted and fragile ecosystems. Global and regional efforts to address environmental and occupational determinants of health largely involve actions that identify and address specific risk factors (such as chemicals, radiation, air pollution and climate change); prevention and management of risks in settings (such as, homes, workplaces, and health-care facilities); and integration of primary prevention interventions into the

[1] The focal point system, which has been the main strategy recognized by the United Nations Chief Executives Board for Coordination system-wide policy on gender equality and the empowerment of women, provides technical support for the integration of gender within WHO programmes at regional and country level, and monitors implementation of the strategy for integrating gender analysis and actions into the work of WHO.

design of policies, plans and projects implemented in sectors with high environmental and occupational risks.

OWER 8.1

Evidence-based assessments made, and norms and standards formulated and updated on major environmental hazards to health (e.g., poor air quality, chemical substances, electromagnetic fields, radon, poor-quality drinking-water and wastewater reuse).

Fully achieved

Indicator		Baseline	Target	Achieved
8.1.1	Number of Member States that have conducted assessments of specific environmental threats to health or have quantified the environmental burden of disease with WHO technical support during the biennium.	42	44	67
8.1.2	Number of new or updated WHO norms, standards or guidelines on occupational or environmental health issues published during the biennium.	18	20	21

166. Overall, knowledge about environmental risk factors to human health in countries across WHO regions has increased. Sixty-seven countries reported conducting assessments of specific environmental threats using WHO tools and guidance on risk assessment, as compared with 42 in the previous biennium. In many instances these actions were as a result of intersectoral political commitments. For example, in the African Region, within the ambit of the Libreville Declaration and follow-up process, 15 countries carried out national environment and health situation analyses and needs assessments with financial and technical support from WHO. Similar momentum was created in the European Region by the Fifth Ministerial Conference on Environment and Health in March 2010; in the South-East Asia Region by the Second Ministerial Regional Forum on Environment and Health in July 2010; and in the Western Pacific Region by the Second East Asia Ministerial Conference on Sanitation and Hygiene in January 2010.

OWER 8.2

Technical support and guidance provided to Member States for the implementation of primary prevention interventions that reduce environmental hazards to health, enhance safety and promote public health, including in specific settings (e.g. workplaces, homes or urban settings) and among vulnerable population groups (e.g. children).

Partly achieved

Indicator		Baseline	Target	Achieved
8.2.1	Number of Member States implementing primary prevention interventions for reducing environmental risks to health, with WHO technical support, in at least one of the following settings: workplaces, homes or urban settings.	48	52	92

167. A total of 92 countries reported scaling up the use of primary prevention interventions to address environmental and occupational determinants of health. For example, many countries have stepped up household water treatment and safe storage interventions to ensure safe drinking-water. Country-level activities have been guided by the use of WHO *Guidelines for Drinking-water Quality*, updated in 2010, and by WHO information materials on the safe use of wastewater, excreta, and grey water, revised in April 2010. Another example, carried out in collaboration with the GAVI Alliance, includes the provision of technical support to 27 countries in the African Region and six in the Eastern Mediterranean Region to develop and implement national plans for health-care waste management.

168. In September 2010, the Global Alliance for Clean Cookstoves, of which WHO is a founding member, was launched with the aim of saving the lives of the 1.9 million people who, as a result of exposure to air pollution from solid fuel, die prematurely from among other diseases or conditions, childhood pneumonia, cardiovascular disease, chronic obstructive pulmonary disease and low birth weight. Through the Global Alliance, 100 million homes in low- and middle-income countries will be provided with access to clean cookstoves. In September 2011, WHO launched the global database of outdoor air pollution comprising data from nearly 1100 cities across 91 countries.

169. While the indicator targets were achieved, this Organization-wide expected result was assessed to be partly achieved mainly because some risk-communication activities, for example for radiation protection in health-care settings and radon in the home, were deferred to the next biennium because of resource constraints and the need for existing staff to respond to the Fukushima nuclear emergency. Similar human resource constraints were experienced in the Eastern Mediterranean Region for activities planned under this OWER.

OWER 8.3

Technical assistance and support provided to Member States for strengthening national occupational and environmental health risk management systems, functions and services.

Fully achieved

Indicator		Baseline	Target	Achieved
8.3.1	Number of Member States that have implemented national action plans/policies for the management of occupational health risks, such as in relation to the Global Plan of Action on Workers' Health (2008–2017), with support from WHO.	67	72	88

170. National policy frameworks, strategies or action plans to support the management of environmental and occupational risks were put in place in 89 Member States.

171. In the Eastern Mediterranean Region, the Gulf Cooperation Council countries formally adopted the Healthy Workplace initiative in Cairo in January 2010. WHO provided technical support for a regional plan of action to promote healthy workplaces and institutionalize related activities, starting in Egypt and Oman.

172. Similar progress was reported in the South-East Asia Region, where 9 out of 11 countries implemented national activities aimed at achieving the objectives of the Global plan of action on workers' health 2008–2017. Country-level activities to promote and protect the health of health-care

workers have also been scaled up, for example, following the release, in 2010, of the WHO/ILO tool to improve working conditions in the health sector, *HealthWISE*.

OWER 8.4

Guidance, tools and initiatives created in order to support the health sector in influencing policies in other sectors to allow policies that improve health, the environment and safety to be identified and adopted.

Partly achieved

Indicator		Baseline	Target	Achieved
8.4.1	Number of Member States that are implementing WHO-supported initiatives to identify and address the health impacts of activities in one or more of the following sectors: agriculture, energy and transportation.	67	72	Not available

173. During the biennium there was an increase in the systematic use of tools such as environmental health impact assessment. A successful pilot project in the oil sector in Ghana was presented to the Second Inter-Ministerial Conference on Health and Environment in Africa (Luanda, November 2010). Based on the success of such pilot projects, the demand for technical support for health impact assessments is increasing, in particular in the oil and gas and mining industries. In other regions, the use of health impact assessment is gaining increased attention particularly because it is recognized as a tool for addressing health inequities, for optimizing health benefits in response to climate change mitigation and adaptation, and for support of green growth.

174. In the transport sector, initiatives on environmentally sustainable transport and environmentally sustainable and healthy urban transport were launched. Technical support was also provided in six countries for strengthening the public health management of pesticides in the agriculture sector so as to reduce risks posed by pesticides to public health.

175. WHO cosponsored the 1st International Conference on UV and Skin Cancer in May 2011 in Copenhagen that brought together stakeholders from around the world. Work on a booklet compiling policy interventions for sunbeds and a complementary sunbed policy database was initiated.

176. While significant progress has been made, the criteria and methods used for measuring the number of Member States that are implementing WHO-supported initiatives to identify and address the health impacts of activities in agriculture, energy and transportation has been significantly revised during the biennium to ensure a more accurate assessment of achievement. Work is currently progressing to revise the baseline and target values accordingly. It was therefore not possible to provide an achievement value this biennium. In the absence of the indicator results data, this Organization-wide expected result was assessed to be partly achieved based on the technical assessments of the regions and headquarters.

OWER 8.5

Health-sector leadership enhanced for creating a healthier environment and changing policies in all sectors so as to tackle the root causes of environmental threats to health, through means such as

responding to emerging and re-emerging consequences of development on environmental health and altered patterns of consumption and production and to the damaging effect of evolving technologies.

Fully achieved

Indicator		Baseline	Target	Achieved
8.5.1	Number of studies or reports on new and re-emerging occupational and environmental health issues published or co-published by WHO.	15	17	21
8.5.2	Number of reports published or jointly published by WHO on progress made in achieving water and sanitation objectives of major international development frameworks, such as the Millennium Development Goals.	8	10	10
8.5.3	Number of high-level regional forums on environment and health issues organized or technically supported by WHO biennially.	9	10	11

177. Overall, awareness of the health risks associated with chemicals has increased as a result of WHO's normative and risk assessment activities, including publication of reports on key chemicals, including on DDT in indoor residual spraying, and a series addressing ten chemicals of major public health concern.

178. With regard to priority environmental and occupational health concerns in high-level forums and events, including in the context of international environmental agreements and related processes, WHO has also advocated for closer linkages between existing environment and health development goals and objectives, for example, through the first WHO international conference on the primary prevention of cancer through environmental and occupational interventions and the Asturias Declaration in March 2011.

OWER 8.6

Evidence-based policies, strategies and recommendations developed, and technical support provided to Member States for identifying, preventing and tackling public health problems resulting from climate change.

Fully achieved

Indicator		Baseline	Target	Achieved
8.6.1	Number of studies or reports on the public health effects of climate change published or co-published by WHO.	n/a	30	35
8.6.2	Number of countries that have implemented plans to enable the health sector to adapt to the health effects of climate change.	n/a	30	48

179. A total of 30 countries across all WHO regions reported carrying out assessments of health vulnerability and adaptation to climate change, the findings of which are being used in 18 major pilot projects across 14 countries. WHO has continued its advocacy and leadership activities in order to encourage regional and global processes on environment, climate change and sustainable development to take greater account of health.

180. A systematic review of health co-benefits of climate change mitigation policies was carried out in five sectors (housing, transport, agriculture, health and household energy). The results, together with a report prepared by the Regional Office for the Americas (*Environmental and Social Determinants of Health*) were released at the World Conference on Social Determinants of Health in October 2011 and at the Sixteenth and Seventeenth Sessions of the Conference of the Parties to the United Nations Framework Convention on Climate Change in 2010 and 2011, respectively.

STRATEGIC OBJECTIVE 9

To improve nutrition, food safety and food security, throughout the life course, and in support of public health and sustainable development

181. Undernutrition, poor vitamin and mineral status and obesity affect large sections of the global population. Childhood malnutrition is the underlying cause of death in an estimated 35% of all deaths among children under five years of age, and diet, including unsafe food intake, is a major risk factor for diabetes, cardiovascular disease and cancer. Diarrhoeal diseases caused by a variety of pathogens in food and water interact with undernutrition in a vicious cycle negatively affecting development. In 2008, 205 million men and 297 million women over the age of 20 were obese.

182. WHO has been working with national health authorities dealing with nutrition and food safety, as well as representatives of other government sectors, particularly agriculture. WHO's main partners are the United Nations, in particular FAO, UNICEF and the WFP, and international agencies, bilateral and multilateral funding agencies, the scientific community and nongovernmental organizations. Connections have been established with regional institutions, such as the Secretariat of the Pacific Community, the West African Health Organization, the African Union, the New Partnership for Africa's Development, the Comité Permanent Inter Etats de Lutte contre la Sécheresse dans le Sahel (CILSS) and the European Commission.

OWER 9.1

Partnerships and alliances formed, leadership built and coordination and networking developed with all stakeholders at country, regional and global levels, in order to promote advocacy and communication, stimulate intersectoral actions, increase investment in nutrition, food safety and food security interventions, and develop and support a research agenda.

Partly Achieved

Indicator		Baseline	Target	Achieved
9.1.1	Number of Member States that have functional institutionalized coordination mechanisms to promote intersectoral approaches and actions in the area of food safety, food security or nutrition.	89	125	128

Indicator		Baseline	Target	Achieved
9.1.2	Number of Member States that have included nutrition, food-safety and food-security activities and a mechanism for their financing in their sector-wide approaches or Poverty Reduction Strategy Papers.	28	35	117

183. Increased awareness by policy-makers on the importance of food safety and nutrition and improved collaboration between health, agriculture and veterinary sectors, and better coordination between stakeholders has been noted in most countries. This can be evidenced by the fact that the number of Member States that have functional institutionalized coordination mechanisms to promote intersectoral approaches and actions in the area of food safety, food security or nutrition have increased from 89 in 2010 to 128 at the end of the biennium. Several have established a coordination mechanism to promote intersectoral approaches and actions in the area of food safety and nutrition. However, in some regions, national food safety programmes remained compartmentalized with limited collaboration and cooperation between the different sectors.

184. WHO has been engaged in the UN REACH partnership at country level and in the United Nations System Standing Committee on Nutrition at the global level as well as contributing to the development of the *Scaling up Nutrition* initiative by leading the Task Force on monitoring and surveillance and by developing a comprehensive implementation plan on maternal, infant and young child nutrition.

185. WHO also coordinated work on the Global Foodborne Infections Network (GFN) and on the International Food Safety Authorities Network (INFOSAN), which respectively promote integrated, laboratory-based surveillance through training courses and activities around the world, and rapid information exchange and response to outbreak of foodborne illnesses.

186. In addition, WHO increased collaboration with international players focusing on food security issues in order to foster intersectoral collaboration and include food safety into the international discussions on the food crisis. The Secretariat at headquarters strengthened partnerships with the International Livestock Research Institute (ILRI) and the International Food Policy Research Institute (IFPRI) in connection with the research programme “Agriculture for Improved Nutrition and Health” and supported the development of the report submitted to the United Nations Human Rights Council by the United Nations Special Rapporteur on the right to food.

187. This Organization-wide expected result was partly achieved as governance mechanisms at country level still need to be strengthened in the African Region and the Region of the Americas.

OWER 9.2

Norms, including references, requirements, research priorities, guidelines, training manuals and standards, produced and disseminated to Member States in order to increase their capacity to assess and respond to all forms of malnutrition, and zoonotic and non-zoonotic foodborne diseases, and to promote healthy dietary practices.

Fully achieved

Indicator		Baseline	Target	Achieved
9.2.1	Number of new nutrition and food-safety standards, guidelines or training manuals produced and disseminated to Member States and the international community.	23	43[a]	88[b]
9.2.2	Number of new norms, standards, guidelines, tools and training materials for prevention and management of zoonotic and non-zoonotic foodborne diseases.	14	19	20

[a] In addition, the Secretariat committed to develop 200 new Codex Standards.

[b] In addition, a large number of new Codex standards (557) were developed, thanks to a simplification of the approval procedure.

188. A major step forward has been the establishment of a mechanism to provide scientific advice in nutrition, following the WHO guideline process, which is leading to an improvement of the management of malnutrition and micronutrient deficiencies. Similarly, in the area of food safety, the main achievement has been an increased understanding of the importance of science-based food safety standards, i.e. Codex standards, and their implementation for exported foods and for the local food supply.

189. Overall, WHO has produced 65 nutrition and food safety standards, guidelines or training manuals and 557 Codex Standards, which have been disseminated to Member States and the international community. Notably, Codex Guidelines for risk analysis of foodborne antimicrobial resistance were developed. The Secretariat also convened a large number of scientific expert meetings to assess the potential health risks of food additives, contaminants, veterinary drug residues in food, microbiological hazards and emerging issues, and thus provide the evidence base for international standards. WHO's global message "Five keys to safer food" to train food handlers and educate consumers was also widely disseminated.

190. The Nutrition Guidance Expert Advisory Group was established to provide scientific advice on nutrition. Fourteen nutrition guidelines were developed or updated, using the WHO guideline development process. Guidelines are translated and disseminated through the e-Library of Evidence for Nutrition Actions. The target was exceeded as a result of increased efforts to provide scientific advice, together with improved efficiency in the Codex standard-setting process, which led to some additional international food safety standards, including on limiting melamine contamination in powdered infant formula, other foods and animal feed.

191. Risk-assessment methodologies have been published in comprehensive guidance documents, such as the Principles and Methods for the Risk Assessment of Chemicals in Food. The effective participation of developing countries and countries with economies in transition in the Codex process has been further enhanced, as illustrated by the number of countries who are graduating from the Codex Trust Fund but continuing to sustain their participation in Codex.

OWER 9.3

Monitoring and surveillance of needs and assessment and evaluation of responses in the area of nutrition and diet-related chronic diseases strengthened, and ability to identify best policy options improved, in stable and emergency situations.

Fully achieved

Indicator		Baseline	Target	Achieved
9.3.1	Number of Member States that have adopted and implemented the WHO Child Growth Standards.	63	85	115
9.3.2	Number of Member States that have nationally representative surveillance data on major forms of malnutrition.	104	125	142

192. Progress has been made in monitoring nutritional status, foodborne diseases and implementation of food and nutrition policies. The number of Member States which have adopted the WHO growth standards has increased from 63 in 2010, to 115 at the end of the biennium while the number of Member States that have nationally representative surveillance data on major forms of malnutrition has increased from 104 to 142.

193. A childhood obesity surveillance was established in the European Region and a global nutrition policy review that covered 119 Member States and four territories was implemented. In addition, food safety programmes were assessed in 28 countries. The Global Foodborne Infections Network is now including members from 181 Member States and the International Food Safety Authorities Network links 177 Member States, complementing the work being carried out under the International Health Regulations (2005).

194. WHO has maintained and expanded its databases, including child anthropometry, body mass index (BMI) data, vitamins and minerals. The databases are connected through the Nutrition Landscape Information System. The outcomes of the global nutrition policy review are the basis for the new Global database on the Implementation of Nutrition Action. The databases are complemented by other information resources, including indicators' definitions and logical frameworks for indicators' selection, survey methodology tools, and mapping of laboratory capacities. Country, regional and global estimates on child malnutrition, vitamins and minerals and support to growth standard implementation have also been implemented.

OWER 9.4

Capacity built and support provided to target Member States for the development, strengthening and implementation of nutrition plans, policies and programmes aimed at improving nutrition throughout the life-course, in stable and emergency situations.

Partly achieved

Indicator		Baseline	Target	Achieved
9.4.1	Number of Member States that have implemented at least three high-priority actions recommended in the Global Strategy for Infant and Young Child Feeding.	52	97	117
9.4.2	Number of Member States that have implemented strategies to prevent and control micronutrient malnutrition.	44	77	119
9.4.3	Number of Member States that have implemented strategies to promote healthy dietary practices for preventing diet-related chronic diseases.	at least 44	80	138
9.4.4	Number of Member States that have included nutrition in their responses to HIV/AIDS.	14	59	25
9.4.5	Number of Member States that have national preparedness and response plans for nutritional emergencies.	23	47	41

195. The Sixty-third World Health Assembly adopted resolution WHA63.23 on Infant and young child nutrition, which led to the development of a comprehensive implementation plan on maternal, infant and young child nutrition, following regional consultations that involved different government sectors from 92 Member States, United Nations system organizations, development banks, donors and civil society. The number of Member States that have implemented at least three high-priority actions recommended in the global strategy for infant and young child feeding has increased from 52 in 2010 to 117 at the end of the biennium.

196. Regional nutrition strategies have also been developed in the Region of the Americas (Strategy and Plan of Action for the Reduction of Chronic Malnutrition), the Eastern Mediterranean Region (Regional strategy on nutrition 2010–2019), and the South-East Asia Region (Regional nutrition strategy) and WHO has supported Member States in the development and implementation of policies and plans. As a result of this support, the number of Member States that have implemented strategies to prevent and control micronutrient malnutrition has increased from 44 at the beginning of the biennium, to 119 at the end of 2011.

197. Several global documents and meetings dealing with infant, childhood and maternal nutrition and prevention of chronic diseases have emphasized the life-course approach. Member States are aware of the issues involved and considerable awareness exists among the policy-makers and programme managers. As a result of this work, the number of Member States that have implemented strategies to promote healthy dietary practices for preventing diet-related chronic diseases has increased from 44 in 2010 to 138 at the end of the biennium.

198. Despite some major achievements, the Organization-wide expected result was rated as partly achieved as inadequate progress has been made in the Region of the Americas and the South-East Asia Region in implementing nutrition policies and plans. In addition, a significant number of countries are lagging behind in integrating nutritional interventions within their HIV programmes.

OWER 9.5

Systems for surveillance, prevention and control of zoonotic and non-zoonotic foodborne diseases strengthened; food-hazard monitoring and evaluation programmes established and integrated into existing national surveillance systems, and results disseminated to all key players.

Partly achieved

Indicator		Baseline	Target	Achieved
9.5.1	Number of Member States that have established or strengthened intersectoral collaboration for the prevention, control and surveillance of foodborne zoonotic diseases.	66	75	105
9.5.2	Number of Member States that have initiated a plan for the reduction in the incidence of at least one major foodborne zoonotic disease.	68	80	85

199. Several activities were implemented to support the strengthening of food safety institutions and surveillance systems for foodborne diseases and food contamination in Member States. Activities were targeted to promoting intersectoral collaboration between food and public health laboratories and epidemiological services. As a result of this work, the number of Member States that have established or strengthened intersectoral collaboration for the prevention, control and surveillance of foodborne zoonotic diseases has increased from 66 in 2010 to 105 at the end of the biennium. The Sixty-third World Health Assembly adopted resolution WHA63.3 on Advancing food safety initiatives.

200. WHO provided support to countries for strengthening of food safety institutions and foodborne disease surveillance, facilitated research projects on the aetiology, sources of contamination and risk factors for foodborne diseases, and initiated country pilot studies for the assessment of the burden of foodborne diseases.

201. In addition, WHO provided support to monitoring the analytical capacities of food control laboratories and strengthened laboratory capacity through the organization of training courses on foodborne disease surveillance and promotion of intersectoral collaboration between food and public health laboratories and epidemiological services. With regard to the latter, support was provided to countries from all WHO regions through training courses and workshops organized by the WHO Global Foodborne Infections Network, which has network members in 181 Member States.

202. Despite the achievements during the biennium, the Organization-wide expected result was rated as partly achieved as the Regional Office for the Eastern Mediterranean, the Regional Office for South-East Asia and the Regional Office for the Western Pacific all reported their contributions as partly achieved. The main obstacles were the limited inclusion of foodborne diseases in the surveillance systems of most countries, the complexity of coordination and collaboration of stakeholders, which impairs effective food safety monitoring and surveillance; the limited resources in countries to support implementation of total diet studies; and the lengthy processes for the development of foodborne disease burden protocols.

OWER 9.6

Capacity built and support provided to Member States, including their participation in international standard-setting in order to increase their ability to assess risk in the areas of zoonotic and

non-zoonotic foodborne diseases and food safety, and to develop and implement national food-control systems, with links to international emergency systems.

Fully achieved

Indicator		Baseline	Target	Achieved
9.6.1	Number of selected Member States receiving support to participate in international standard-setting activities related to food, such as those of the Codex Alimentarius Commission.	97	85	85
9.6.2	Number of selected Member States that have built national systems for food safety with international links to emergency systems.	59	70	177

203. At a global level, there was a strategic shift of Codex Trust Fund resources to provide more support for improving the quality of participation in Codex training and capacity-building activities, and enhancing the scientific and technical inputs from developing countries for consideration in the Codex.

204. In the South-East Asia Region, an increased number of participants from Member States attended various Codex and INFOSAN meetings. In the European Region, improved knowledge among officials and better intersectoral collaboration during food safety emergencies could be seen in many countries. In the Region of the Americas, 40 countries adopted Codex Alimentarius resolutions. In the Eastern Mediterranean Region, apart from countries in complex emergencies, the majority of countries have laboratories capable of detecting traditional chemical hazards in food. Countries continued to participate in the Codex Alimentarius Commission and Committee meetings as well as in the work of other international standard-setting bodies. The Codex Coordinating Committee for the Near East met in Tunis in May 2011. It assesses risks in food and prepares standards for the traditional foods of the Region. So far, hazard analysis and critical control point generic models exist for 13 traditional foods. Countries continued to strengthen their microbiological and chemical laboratories to enable them to participate in INFOSAN. In conjunction with the implementation of the International Health Regulations (2005) many countries have integrated foodborne disease surveillance within their national disease surveillance. However, the availability of data on foodborne disease and monitoring remains limited. In the Region of the Americas, several countries were supported in either to the drafting or the finalization of their national food safety policies and the evaluation of their food control systems. The WHO “Five Keys to Safer Food” concept was used in addressing food safety arrangements during the preparation and execution of the FIFA World Cup 2010 in South Africa.

STRATEGIC OBJECTIVE 10

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

205. The global financial difficulties of the biennium added an additional dimension to the challenges faced by countries seeking to develop their health systems. The crisis added increased financial constraints to ongoing problems associated with achievement of the health-related Millennium Development Goals, such as fragmented and low-quality service delivery compromising

patient safety; lack of timely information and sufficient information systems (including vital registration), communication technologies and research capacity to produce data; shortages or low morale of health-care providers; inequitable access to services, and heavy reliance on direct out-of-pocket payments to finance health services.

OWER 10.1

Management and organization of integrated, population-based health-service delivery through public and non-public providers and networks improved, reflecting the primary health care strategy, scaling up coverage, equity, quality and safety of personal and population-based health services, and enhancing health outcomes.

Fully achieved

Indicator		Baseline	Target	Achieved
10.1.1	Number of Member States that have regularly updated databases on numbers and distribution of health facilities and health interventions offered.	30	35	73

206. There is an increasing interest at country level and within the Secretariat in the promotion and development of service delivery based on integrated primary care. This is particularly the case in middle- and high-income countries. In a number of countries, primary care is starting to take on a role that includes more coordination. Enhanced and continued integration of noncommunicable diseases and their common risk factors introduces cross-cutting platforms, reduces the downsides associated with vertical approaches, and strengthens primary health care-based health systems.

207. During the biennium, the number of Member States that have regularly updated databases giving the number and distribution of health facilities and health interventions offered increased from 30 in 2010 to 73 at the end of 2011. Twenty-one countries have made advances in implementing and monitoring reforms to strengthen primary health care.

208. Normative work has progressed in formulating guidance on service delivery, in such areas as people-centred care, district planning, hospital services, regulation of the commercialization of health services, the regulation of traditional and complementary medicine, and participation.

209. There still remains a disconnect between the importance of the hospital reform agenda for national health authorities and the attention this is given in the global health and aid environment. This hampers the development of coherent approaches to service delivery.

OWER 10.2

National capacities for governance and leadership improved through evidence-based policy dialogue, institutional capacity-building for policy analysis and development, strategy-based health system performance assessment, greater transparency and accountability for performance, and more effective intersectoral collaboration.

Fully achieved

Indicator		Baseline	Target	Achieved
10.2.1	Number of Member States that have in the last five years developed comprehensive national health planning processes in consultation with stakeholders.	92	107	108
10.2.2	Number of Member States that conducted a regular or periodic evaluation of progress, including implementation of their national health plan, based on a commonly agreed performance assessment of their health system.	54	65	69

210. Countries made advances in the formulation and implementation of their national health policies, strategies and plans. Globally, 108 countries have put in place comprehensive national planning processes with varying degrees of stakeholder involvement in the national policy dialogue. Sixty-nine Member States conducted participatory health sector reviews and progress evaluations based on agreed health system performance assessment criteria. Joint assessments of national strategies were successfully conducted in 10 countries. In the Region of the Americas, regulatory frameworks and legislation were revised and updated in 11 countries. In the European Region, six countries completed a health system performance assessment exercise. In the Eastern Mediterranean Region, 13 countries conducted assessment studies on regulations of the private sector. Road maps on information and accountability were developed for at least six countries by the Commission on Information and Accountability.

OWER 10.3

Coordination of the various mechanisms (including donor assistance) that provide support to Member States in their efforts to achieve national targets for health-system development and global health goals improved.

Partly achieved

Indicator		Baseline	Target	Achieved
10.3.1	Number of Member States where the inputs of major stakeholders are harmonized with national policies, measured in line with the Paris Declaration on Aid Effectiveness.	25	30	52

211. The International Health Partnership (IHP+) aims to accelerate better health outcomes through greater alignment of partners with national health strategies. WHO and the World Bank jointly serve as the Secretariat for IHP+. During the biennium under review, the number of signatories of the IHP+ Global Compact has grown from 25 to 52, of which 30 are developing countries. During the biennium 10 developing countries and 15 development agencies participated in the second round of IHP+ Results. In parallel with this effort, ministries of health are developing and organizing more comprehensive stakeholder/donor coordination mechanisms such as sector-wide approaches and joint assessments of national strategies. The Secretariat continues to play a significant role in supporting Member States in such coordination efforts.

212. Organization-wide expected result 10.3 was "partly achieved" as the Region of the Americas and the South East-Asia Region reported their contribution as being partly achieved. The main challenge to fully achieving the result is that it requires time for institutions to adapt to harmonizing their own policies with national ones and those of partner agencies.

OWER 10.4

Country health-information systems that provide and use high-quality and timely information for health planning and for monitoring progress towards national and major international goals strengthened.

Fully Achieved

Indicator		Baseline	Target	Achieved
10.4.1	Proportion of low- and middle-income countries with adequate health statistics and monitoring of health-related Millennium Development Goals that meet agreed standards.	40%	45%	48%

213. There is increasing commitment to the strengthening of health information systems in many countries. This includes completion of the Health Metrics Network/WHO assessment, development of strategic plans, gradual improvement of analytical capacity and better availability of data. The latter occurs mainly through household surveys, but there are also efforts to improve facility based reporting systems. This biennium, the proportion of low- and middle-income countries with adequate health statistics and monitoring of health-related Millennium Development Goals that meet agreed standards increased from 40% to 48%.

214. WHO contributed to the strengthening of country health information systems through the development and promotion of standards and tools, capacity building and support to regional networks. The normative work to support countries involved joint development of tools for better data collection through e.g. the Service Availability and Readiness Assessment facility survey (SARA), assessment of data quality, monitoring the health information system performance, and a framework for monitoring and evaluation for information and accountability/health reviews (WHO and IHP+. "Monitoring, evaluation and review of country health strategies: a country-led platform for information and accountability").

215. WHO supported the strengthening of the analytical capacity of countries in the context of health sector reviews and annual health statistical reporting. This involved joint development of tools, multi-country workshops to enhance analytical capacity (4 were conducted during the period 2010–2011 in the African Region, Eastern Mediterranean Region, South East Asia Region and Western Pacific Region, covering in total more than 30 countries).

OWER 10.5

Better knowledge and evidence for health decision-making assured through consolidation and publication of existing evidence, facilitation of knowledge generation in priority areas, and global leadership in health research policy and coordination, including with regard to ethical conduct.

Partly achieved

Indicator		Baseline	Target	Achieved
10.5.1	Proportion of countries for which high quality profiles with core health statistics are available from its open-access databases.	85%	90%	98%
10.5.2	Number of countries in which WHO plays a key role in supporting the generation and use of information and knowledge, including primary data collection through surveys, civil registration or improvement or analysis and synthesis of health facility data for policies and planning.	30	35	36
10.5.3	Effective research for health coordination and leadership mechanisms established and maintained at global and regional levels.	In progress, at different stages at global and regional levels	Mechanisms operating at global and all regional levels	Global research for health strategy established at WHO headquarters. Regional strategies established in 4 Regional Offices[a]

[a] Regional strategies established in the African Region, the Region of the Americas, the Eastern Mediterranean and South-East Asia Regions. The Western Pacific Region and South-East Asia Region have established an Asia Pacific Observatory on Health Systems and Policies, which is recognized as a leadership mechanism on evidence-based policy development.

216. There is a gradual improvement in the availability and reporting of quality health data by countries. Statistical profiles for countries are improving, but major gaps such as causes of death remain in many countries with virtually no improvement during the last decade.

217. WHO regional offices and headquarters collaborated in further developing WHO observatories to monitor the health situation and trends for priority public health topics. Progress was made in sharing data and statistics on countries between offices and with the general public. The proportion of countries which have statistical profiles that are available from WHO databases has increased from 85% at the beginning of the biennium to 98% at the end of the biennium, but there is still too much reliance on modelling to fill data gaps, especially for low-income countries.

218. WHO continues to engage with countries through surveys on adult health and ageing, strengthening of vital statistics systems and comprehensive analyses to inform health-sector reforms and reviews. As a result, the number of countries in which WHO plays a key role in supporting the generation and use of information and knowledge, including primary data collection through surveys, civil registration or improvement or analysis and synthesis of health facility data for policies and planning, has increased from 30 in 2010 to 36 at the end of the biennium.

219. Although good progress was made, the African Region and South-East Asia Region reported their contribution as being “partly achieved”, given that fragmentation in their capacity to collect evidence for health decision-making for health research policy and coordination, including with regard to ethical conduct, remained a major challenge.

OWER 10.6

National health research for development of health systems strengthened in the context of regional and international research and engagement of civil society.

Partly achieved

Indicator		Baseline	Target	Achieved
10.6.1	Proportion of low- and middle-income countries in which national health-research systems meet internationally agreed minimum standards.	10%	15%	40%
10.6.2	Number of Member States complying with the recommendation to dedicate at least 2% of their health budget to research (Commission on Health Research for Development, 1990).	15%	8% increase from 2009 target	Not available[a]

[a] Indicator 10.6.2 is not a precise measure of country support for research and development and therefore this indicator will be discontinued in 2012–2013. While it can be self-reported by countries WHO is unable – with its current resources – to verify these figures.

220. The WHO strategy on research for health provided a common framework for the organization of WHO support to Member States. The strengthening of research for development activities within countries is reported from five of the six Regional Offices.

221. The presence of the Evidence-Informed Policy Networks (EVIPNet) initiative in a growing number of countries has enhanced evidence-based policy-making. The European Region has recently made research and evidence for policy key priority outcomes. A result has been the formal reconstitution of the European Advisory Committee on Health Research, beginning work towards developing a regional research for health strategy and the establishment of a regional EVIPNet (Evidence Informed Policy Network).

222. At headquarters, implementation of the research strategy has been harmonized with that of the global strategy and plan of action on public health, innovation and intellectual property. The research for health strategy has been used to guide the development of a research agenda in a number of technical areas including: influenza, foodborne diseases, radiation risks, vaccines, social determinants of health, and was used in the *Women and Health* report to develop a six-point agenda for a gender-based approach to research.

223. This Organization-wide expected result was overall partly achieved, with the African Region, European Region, South-East Asia Region and Western Pacific Region as well as headquarters all reporting their contributions as having been partly achieved. Obtaining reliable high-level data on research and development resource flows and mapping remains very difficult in the absence of global standards on the classification and reporting of these data.

OWER 10.7

Knowledge management and eHealth policies and strategies developed and implemented in order to strengthen health systems.

Partly achieved

Indicator		Baseline	Target	Achieved
10.7.1	Number of Member States adopting knowledge management policies in order to bridge the "know-how" gap particularly aimed to decrease the digital divide.	87	100	Not available[a]
10.7.2	Number of Member States with access to electronic international scientific journals and knowledge archives in health sciences as assessed by the WHO Global Observatory for eHealth biannual survey.	159	170	162
10.7.3	Proportion of Member States with eHealth policies, strategies and regulatory frameworks as assessed by the WHO Global Observatory for eHealth biannual survey.	53	75	75

[a] Indicator 10.7.1 is being discontinued due to feedback by Member States stating that it was ambiguous and not easily measured. This indicator will be replaced for the assessment of the period 2012–2013.

224. There is an expanded uptake of eHealth applications, especially mHealth,[1] and development of virtual platforms for knowledge sharing, as well as a steady increase in access to scientific literature. Increased support to eHealth is noted by resolutions in the African Region and the Region of the Americas. In the European Region, WHO advised on e-strategies and development, including at European Union Ministerial conferences. The South-East Asia Region and Western Pacific Region have active regional eHealth networks, with countries building strategies and regulatory frameworks.

225. The Global Observatory for eHealth reports covered mHealth, legal issues, online safety, patient information systems and telemedicine. One hundred and fourteen countries have contributed to the Global Observatory of eHealth survey. All countries have access to the results of the survey in the form of published reports. The number of countries with eHealth policies increased from 53 at the beginning of the biennium to 75 by the end of 2011.

226. The HINARI Access to Research in Health Programme remains an area of rapid growth in registered institutions in all regions and has increasing content from publisher partners. eLearning and virtual libraries have become an integral part of the work of the Organization and its outreach to Member States. A compendium of available eLearning modules developed by WHO technical units has been prepared and published online.

227. Despite further progress, the Organization-wide expected result 10.7 was "partly achieved" due to varying levels of effort in countries and regions, especially in the European Region and the South-East Asia Region, the lack of national policies, and lack of working together within and across organizational boundaries. Indicator 10.7.1 was reported as being "on track" at the end of 2010 during the mid-term review of the implementation of the Programme budget 2010–2011, as efforts were being undertaken during 2011 to find an alternative measurement methodology under the current definition. However, after consultation with regional and country offices, it was decided that this indicator will be discontinued and therefore no data are provided for the period 2010–2011.

[1] mHealth refers to the use of mobile and wireless technologies to support the achievement of health objectives.

OWER 10.8

Health-workforce information and knowledge base strengthened, and country capacities for policy analysis, planning, implementation, information-sharing and research built up.

Fully achieved

Indicator		Baseline	Target	Achieved
10.8.1	Number of countries reporting two or more national data points on human resources for health within the past five years, reported in the Global Atlas of the Health Workforce.	85	96	127
10.8.2	Number of Member states with a national policy and planning unit for human resources for health.	41	50	90

228. Countries have progressed in the collection and analysis of data on the health workforce. The number of Member States with a national policy and planning unit for human resources for health has increased from 41 in 2010 to 90 at the end of the biennium. In addition, the number of Member States reporting two or more national data points on human resources for health within the past five years has increased from 85 at the beginning of the biennium to 127 by the end.

229. Technical support was provided to countries by regional offices, in collaboration with headquarters, in various areas of human resources for health governance and evidence generation, such as policy and plan development, the establishment of national observatories in human resources for health and the strengthening of information systems and capacity building on planning.

230. WHO continued to work with partners in the Health Workforce Information Reference Group to develop global guidelines for generating information on the health workforce; and to establish health workforce observatories to address current deficiencies. The *Global Atlas of the Health Workforce* was last updated in late 2010. The Atlas collects information from various sources in countries and is a global resource for health workforce statistics.

OWER 10.9

Technical support provided to Member States, with a focus on those facing severe health-workforce difficulties in order to improve the production, distribution, skill mix and retention of the health workforce.

Fully achieved

Indicator		Baseline	Target	Achieved
10.9.1	Proportion of 57 countries with critical shortage of health workforce, as identified in *The world health report 2006* with a multi-year HRH plan.	42%	30%	61%

Indicator		Baseline	Target	Achieved
10.9.2	Proportion of 57 countries with critical shortage of health workforce, as identified in *The world health report 2006* which have an investment plan for scaling up training and education of health workers.	16%	25%	35%

231. WHO and its partners, including the Global Health Workforce Alliance, the European Commission and the United States Agency for International Development, directed technical support and investment towards at least 41 countries experiencing a health workforce crisis in support to health workforce planning, improvement of information systems, including health workforce observatories, educational programmes for professionals, task shifting, and retention strategies.

232. Thirty-five countries of the 57 (61%) with a critical shortage of health workforce have multi-year human resources plans a major increase when compared to the baseline in 2010 of 42%. In addition, 20 countries that have an investment plan for scaling up training and education of health workers increased from 16% in 2010 to 35% by the end of the biennium. In many countries, special attention was given to increasing the production of health workforce and to improving the quality and relevance of health personnel education.

233. At global level, and after three years of international consultations, the WHO Global Code of Practice on the International Recruitment of Health Personnel was adopted by the Sixty-third World Health Assembly.[1] An implementation strategy was completed and draft guidelines for reporting on country activities in connection with the implementation of the Code of Practice are being prepared. In addition, WHO is collaborating, with the United States President's Emergency Plan for AIDS Relief, on the transformative scale-up of health professional education towards the development of guidelines on education by 2012.

OWER 10.10

Evidence-based policy and technical support provided to Member States in order to improve health-system financing in terms of the availability of funds, social and financial-risk protection, equity, access to services and efficiency of resource use.

Fully achieved

Indicator		Baseline	Target	Achieved
10.10.1	Number of Member States provided with technical and policy support to raise additional funds for health; to reduce financial barriers to access, incidence of financial catastrophe, and impoverishment linked to health payments; or to improve social protection and the efficiency and equity of resource use.	66	45	77

[1] Resolution WHA63.16.

Indicator		Baseline	Target	Achieved
10.10.2	Number of key policy briefs prepared, disseminated and their use supported, which document best practices on revenue-raising, pooling and purchasing, including contracting, provision of interventions and services, and handling of fragmentation in systems associated with vertical programmes and inflow of international funds.	7 additional briefs	17 technical briefs	24 technical briefs, over 75 information products of other types

234. There was a substantial increase in the number of countries seeking technical support to review or develop their health financing systems with a view to moving closer to or maintaining universal coverage. By the end of 2011, 77 Member States had received technical and policy support. This covered areas such as raising more funds for health, reducing financial barriers to access and improving financial risk protection, and improving the efficiency and equity of resource allocation decisions.

235. WHO provided technical support to 67 Member States across all regions for assessing their status in terms of universal coverage and the functioning of their current health financing systems, and in developing and implementing strategies to move closer to universal coverage.

236. The topic of *The world health report 2010* was health system financing: the path to universal coverage. It aimed to focus attention globally and at country level on the important role of health financing in ensuring that all people have access to the health services they need without fear of financial ruin. It supported the sharing of experiences across countries on what worked and what did not. Resolution WHA64.9 on Sustainable health financing structures and universal coverage was adopted by the Sixty-fourth World Health Assembly in 2011. It urged the Director-General, among other things, to develop an action plan for health financing and universal coverage. Accordingly, the action plan was prepared, after input from regions, country offices and other partners. WHO has advocated strongly, in collaboration with partners including civil society, for the need to reduce financial barriers to accessing health services, and to ensure that universal coverage is recognized as a fundamental goal not only of health policy, but of development strategies.

OWER 10.11

Norms, standards and measurement tools developed for tracking resources, estimating the economic consequences of illness, and the costs and effects of interventions, financial catastrophe, impoverishment, and social exclusion, and their use supported and monitored.

Fully achieved

Indicator		Baseline	Target	Achieved
10.11.1	Key tools, norms and standards to guide policy development and implementation developed, disseminated and their use supported, according to expressed need, that comprise resource tracking and allocation, budgeting, financial management, economic consequences of disease and social exclusion,	Guidelines on economic burden completed; in progress: a United Nations costing and impact tool and	Tools and frameworks modified, updated and disseminated as necessary	Tools and frameworks modified, updated and disseminated as necessary[a]

Indicator		Baseline	Target	Achieved
	organization and efficiency of service delivery, including contracting, or the incidence of financial catastrophe and impoverishment.	revision of the national health accounts system		
10.11.2	Number of Member States provided with technical support for using WHO tools to track and evaluate the adequacy and use of funds, to estimate future financial needs, to manage and monitor available funds, or to track the impact of financing policy on households.	34	50	70

[a] OneHealth cost and impact tool, SHA2011, RMNCH-GET tool, EPIC economic impact tool, macroeconomics and health tool and guidelines on Medium-term expenditure frameworks and public expenditure and financial management.

237. Countries increasingly kept track of the resources they spent on health and sought to link resources to results. More Member States also reviewed where they stood with respect to universal coverage (particularly levels and distribution of funds for health, and the incidence of financial catastrophe and impoverishment linked to out-of-pocket health payments); assessed their health financing systems; developed/modified strategies; and examined the cost and resource constraints associated with particular health financing strategies and health plans.

238. Technical support was started for countries wishing to use the new tools and guidelines described below. It continued for those wishing to track expenditure including on particular diseases, assess the extent of financial catastrophe and impoverishment linked to out-of-pocket payments, evaluate the cost and impact of different strategies and health intervention, and assess their overall health financing systems. The OneHealth cost and impact tool, jointly developed with five other international agencies, was finalized for the diseases/conditions linked to the Millennium Development Goals and for associated health system strengthening, and tested in countries. It will be used by all participating agencies in supporting countries to assess the cost and impact of national health plans and strategies.

239. SHA2011 – the revised system of health accounts – was finalized jointly with OECD and EUROSTAT and translated by WHO into French, Russian and Spanish. The Secretariat developed and disseminated guidelines and a tool (EPIC) on measuring the economic impact of disease. The Regional Office for the Western Pacific produced a macroeconomics and health tool; the Regional Office for Africa produced *Guidelines for developing medium-term expenditure frameworks* and gathered information on public expenditure and financial management. Finally, WHO-CHOICE (cost–effectiveness) contextualization studies were undertaken with three Member States: on breast cancer control in two, and on alcohol and tobacco control in the third.

OWER 10.12

Steps taken to advocate additional funds for health where necessary; to build capacity in framing of health-financing policy and interpretation and use of financial information; and to stimulate the generation and translation of knowledge to support policy development.

Partly achieved

Indicator		Baseline	Target	Achieved
10.12.1	WHO presence and leadership in international, regional and national partnerships and use of its evidence in order to increase financing for health in low-income countries, or provide support to countries in design and monitoring of Poverty Reduction Strategy Papers, sector-wide approaches, medium-term expenditure frameworks, and other long-term financing mechanisms capable of providing social health protection consistent with primary health care.	Participation in 6 partnerships. Support for long-term financing options to 27 countries	WHO participation in 4 partnerships	WHO participation in 5 partnerships and support on long-term financing options provided to 46 countries
10.12.2	Number of Member States provided with support to build capacity in the formulation of health financing policies and strategies and the interpretation of financial data, or with key information on health expenditures, financing, efficiency and equity to guide the process.	57 countries supported for health expenditures; annual updates of reports to all Member States	Annual updates of health expenditures for Member States, together with capacity building exercises in 60 countries	Annual updates of health expenditures produced after consultation with Member States. Capacity building in one or more of the WHO tools provided to 67 countries

240. There were increasing demands from Member States for capacity building exercises linked to the various aspects of health financing: assessing financial catastrophe and impoverishment; tracking resources and linking to results, including disease-specific resource tracking; costing plans and strategies; and assessing financing options for moving closer to universal coverage.

241. In addition, most of the targets for WHO's country support, capacity building, and development and dissemination of information products were achieved, including annual updates of country health expenditures in the global health expenditure database, for which WHO supported 67 countries as at the end of 2011.

242. WHO participated in the Providing for Health (P4H) and the Harmonization for Health in Africa (HHA) Partnerships as well as in formal partnerships to develop OneHealth, SHA2011 and the institutionalization of expenditure tracking. It engaged with regional agencies such as the African Union, and the United Nations' Economic Commission for Africa and Economic Commissions for Latin America and the Caribbean and the Economic and Social Commission for Asia and the Pacific on questions of health financing, and with bilateral and multilateral partners on SWaps. An Atlas on "The situation on Health Financing in Africa" was prepared for 46 countries in the African Region providing health expenditure data and was posted on the WHO web site to be used by countries.

243. This Organization-wide expected result was partly achieved as the African Region and the South-East Asia Region reported their contributions as having been partly achieved. The main challenge is that more data on key components of universal coverage are required, especially on groups that are unable to use services for financial reasons.

OWER 10.13

Evidence based norms, standards and measurement tools developed to support Member States to quantify and decrease the level of unsafe health care provided.

Partly achieved

Indicator		Baseline	Target	Achieved
10.13.1	Key tools, norms and standards to guide policy development, measurement and implementation disseminated and their use supported.	1 global safety standards and 10 major supporting tools	2 global safety standards and 20 major supporting tools	6 standards and 15 tools
10.13.2	Number of Member States participating in global patient safety challenges and other global safety initiatives, including research and measurement.	30	45	69

244. Member States have shown strong engagement in the area of patient safety. The number of Member States participating in global patient safety challenges and other global safety initiatives, including research and measurement has increased from 30 in 2010 to 69 at the end of the biennium.

245. Major achievements this biennium include improved surgical safety practices in over 4100 hospitals in countries in all six WHO regions based on creation, dissemination and support of the WHO Safe Surgery Checklist; improved hand-hygiene practices in countries based on engagement with 5 May "Global Hand Hygiene Day: Save Lives Clean Your Hands"; engagement in patient safety research projects in the Region of the Americas and the Eastern Mediterranean Region; improved patient safety practices in African hospitals in 14 countries; improved medication safety and safe surgery practices in hospitals in nine countries taking part in the WHO "High 5s" hospital improvement project.

246. The Secretariat has provided specific technical support to each region. For example the patient engagement work was reinforced in the African Region through a workshop on "Patients for Patient Safety" including participants from eight countries. In the Eastern Mediterranean Region, the Patient Safety Friendly Hospital Initiative has developed a patient safety improvement toolkit that gives guidance regarding infection prevention and control, setting up a patient safety programme, reporting, implementation of safe surgery, safe clinical practices, blood transfusion, injection safety, and a safe environment.

247. Despite these major achievements, the Organization-wide expected result was reported as being partly achieved, since the African Region and South-East Asia Region have reported their contributions as being partly achieved. Further progress on this Organization-wide expected result was

impeded by the introduction of new concepts of quality in health-care systems, so that quality measures, improvement tools and the global burden have not yet been estimated.

STRATEGIC OBJECTIVE 11

To ensure improved access, quality and use of medical products and technologies

248. WHO aims to improve access to quality assured medical products by supporting countries in the implementation of effective policies, which include promotion of sustainable financing, efficient supply management and rational use. WHO also supports the strengthening of Member States' regulatory and enforcement systems to counteract the likelihood of substandard and counterfeit medical products. In addition, WHO works to build capacity, technical guidance and commitment to address the growing risk of antimicrobial resistance.

249. WHO's efforts to ensure improved access to and quality and use of medical products and technologies are guided by Millennium Development Goals 4 (Reduce child mortality), 5 (Improve maternal health), 6 (Combat HIV/AIDS, malaria and other diseases) and target 8E (access to affordable essential medicines); the third WHO Medicines Strategy 2008–2013; the global strategy and plan of action on public health, innovation and intellectual property; the Global immunization vision and strategy; and several resolutions. A number of regional strategies have also been developed.

OWER 11.1

Formulation and monitoring of comprehensive national policies on access, quality and use of essential medical products and technologies advocated and supported.

Fully achieved

Indicator		Baseline	Target	Achieved
11.1.1	Number of Member States receiving support to formulate and implement official national policies on access, quality and use of essential medical products or technologies.	88	90	118
11.1.2	Number of Member States receiving support to design or strengthen comprehensive national procurement or supply systems.	48	40	68
11.1.3	Number of Member States receiving support to formulate and/or implement national strategies and regulatory mechanisms for blood and blood products or infection control.	26	25	68
11.1.4	Publication of a biennial global report on medicine prices, availability and affordability, based on all available regional and national reports.	2 United Nations reports published in 2008 and 2009	Report published	1 report published (2011)

250. Member States have shown strong political commitment to developing national medicines policies and the Secretariat provided technical support to 118 countries, surpassing the original target of 90. Some countries are focusing on implementation of reforms for equitable access to quality-assured essential medicines and others on implementing programmes to improve transparency and good governance in pharmaceutical systems (31 countries).

251. In addition, technical advice, guidance material and support were provided to 68 Member States to design or strengthen comprehensive national procurement or supply systems.

252. WHO has supported 15 Member States of the European Region in policy formulation and implementation, and collaborates with all European Union countries on best-practice approaches and information exchange. Six countries have received direct support in the area of procurement and supply management. Procurement and supply systems were assessed and support was provided to expand access to HIV/AIDS and tuberculosis medicines in collaboration with projects supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria.

253. Pharmaceutical sector assessments, mapping of procurement and supply, and medicine price surveys contributed to improved knowledge, policies and capacity of the pharmaceutical sector in countries as well as to transparency, as more information is disclosed in the public domain. Over 1000 publications on national medicine policies, including more than 200 country surveys are now available on the WHO web site and a system is available to upload key medicines data on the Global Health Observatory.

254. The third edition of the *World Medicines Situation Report 2011* was published. It brings together in one place new data on 24 key topics relating to pharmaceutical production and consumption, innovation, regulation and safety. Topics include selection, procurement, supply management, rational use, financing and pricing. Cross-cutting chapters cover household medicines use, access and human rights, good governance, human resources and national medicines policies.

255. Additionally, WHO has collaborated with the Global Fund to Fight AIDS, Tuberculosis and Malaria in order to develop harmonized pharmaceutical sector country profiles that provide important information for the strengthening of core regulatory functions for procurement and supply of health commodities. Profiles have been completed in 120 countries.

256. Achievements would have been even higher in 2011 without the political unrest and conflicts experienced in a number of countries, in particular in the Eastern Mediterranean Region. The lack of human resources for the pharmaceutical and health products sectors has also been a challenge.

OWER 11.2

International norms, standards and guidelines for the quality, safety, efficacy and cost-effective use of medical products and technologies developed and their national and/or regional implementation advocated and supported.

Fully achieved

Indicator		Baseline	Target	Achieved
11.2.1	Number of new or updated global quality standards, reference preparations, guidelines and tools for improving the provision, management, use, quality, or effective regulation of medical products and technologies.	More than 30 additional[a]	15 additional	Additional 61[b]
11.2.2	Number of assigned International Nonproprietary Names for medical products.	8 199	8 500	8 552
11.2.3	Number of priority medicines, vaccines, diagnostic tools and items of equipment that are prequalified for United Nations procurement.	239 medicines and 98 vaccines	300	320 (274 medicines 35 APIs[c] 11 diagnostic tools, 134 vaccines)
11.2.4	Number of Member States for which the functionality of the national regulatory authorities has been assessed or supported.	70	75	102

[a] Medicines: 67 monographs, seven reference standards, 30 reference spectra and 10 quality guidelines. Vaccines: three written standards and 16 reference preparations. Technology: 12 written tools and standards.

[b] Medicines: More than 20 new global monographs, one new international chemical reference standard, and 10 new quality assurance guidelines. Vaccines: Twelve measurement standards, 3 new guidelines and 5 updated guidelines; Technologies: 4 Guidelines and 2 assessment tools.

[c] Active Pharmaceutical Ingredients.

257. The Secretariat has continued to develop and update its normative guidance for medicines, medical technologies and vaccines and to provide technical support to countries.

258. Efforts under the WHO Prequalification of Medicines Programme continued and ensured that another 36 medicines were prequalified as a priority, namely HIV/AIDS, malaria, tuberculosis and reproductive health, bringing the total number of prequalified medicines to 274. Six new national quality control laboratories for medicines were prequalified, bringing the total to 23. The WHO Prequalification of Diagnostics Programme prequalified 11 products and another 35 assessments are in the pipeline. Annually, over 40 million HIV and malaria rapid tests are procured and prequalification ensures that public funds are spent on quality products. A new procedure was adopted for defining the programmatic suitability of vaccines for prequalification. A total of 134 vaccines were prequalified for United Nations procurement and 64% of the global infant population has been immunized with WHO prequalified vaccines.

259. A number of countries have been working to complete assessments of core regulatory functions and of these, Argentina, Brazil, Colombia and Cuba have been designated as a National Regulatory Authority of regional reference. In addition, institutional development programmes to strengthen the capacity of other national regulatory authorities of the Region of the Americas are under development and will be supported by the reference National Regulatory Authorities.

260. The last biennium saw growing activity and commitment among Member States to strengthen their regulatory capacities in order to ensure medicine quality and to combat substandard/spurious/ falsely-labelled/falsified/counterfeit medical products.

261. The Working Group of Member States on Substandard/Spurious/Falsely-Labelled/Falsified/ Counterfeit Medical Products met twice in 2011, with more than 90 Member States participating. The Working Group examined the following matters from a public health perspective: (a) WHO's role in measures to ensure the availability of quality, safe, efficacious and affordable medical products; (b) WHO's role in the prevention and control of medical products of compromised quality, safety and efficacy such as substandard/spurious/falsely-labelled/falsified/counterfeit medical products from a public health perspective, excluding trade and intellectual property considerations and (c) WHO's relationship with the International Medical Products Anti-Counterfeiting Taskforce.

262. In the area of immunization, vaccines and biologicals, all 12 countries in the Global Network for Post-marketing Surveillance of Prequalified Vaccines received financial and technical support to strengthen their capacities to monitor the safety of vaccines used in their immunization programmes and thereby ensure delivery of safe vaccines.

263. In the African Region, 25 countries are now implementing a "fast track" registration procedure for the newly licensed and prequalified meningococcal A conjugate vaccine. Regulatory authorities in 33 out of 44 vaccine-producing countries have been assessed as functional and oversight of vaccines in China, Egypt and Iran has led to a 20% increase in the global availability of quality-assured vaccine doses. The Lao Democratic People's Republic, the Philippines and South Africa are improving their blood transfusion services and developing national blood policies, while Mauritius, Namibia and Tanzania are developing national policies on human organ transplantation.

264. This Organization-wide expected result has been fully achieved and in some instances, achievements have been well above the targets identified in 2011. This could be explained by the fact that realistic targets were set and that countries have identified medicines policies as a high priority within their health and development agenda and have therefore surpassed expectations on investment in medicines policies and requests for support from WHO.

OWER 11.3

Evidence-based policy guidance on promoting scientifically sound and cost-effective use of medical products and technologies by health workers and consumers developed and supported within the Secretariat and regional and national programmes.

Partly achieved

Indicator		Baseline	Target	Achieved
11.3.1	Number of national or regional programmes receiving support for promoting sound and cost-effective use of medical products or technologies.	50	40	78
11.3.2	Number of Member States using national lists, updated within the past five years, of essential medicines, vaccines or technologies for public procurement or reimbursement.	125 (94% of reporting countries)	135	94

265. The WHO Secretariat has revised and published the *17th WHO Model List of Essential Medicines* and the *3rd Model List of Essential Medicines for Children*. WHO has supported countries such as the Central African Republic, Democratic Republic of Congo, Ethiopia, Mali and Rwanda in the successful updating of their essential medicines lists and standard treatment guidelines. Rational use was also promoted through the establishment of Drugs and Therapeutics Committees. By the end of the biennium, 94 Member States had updated national lists, adapted from the *WHO Model List of Essential Medicines*.

266. On World Health Day 2011, WHO introduced a six-point policy package to combat the spread of antimicrobial resistance. A WHO Working Group on Antimicrobial Resistance will elaborate an Organization-wide collaborative workplan for 2012–2013. The 3rd International Conference on Improved Use of Medicines held in Turkey in 2011 was attended by nearly 600 participants from 86 countries, testifying to the growing interest in promoting the rational use of medicines at national and regional level. A situational analysis with a particular focus on promoting the rational use of medicines, as recommended by resolution SEA/RC64/R5, was undertaken in 7 out of 11 countries of the South-East Asia Region, and technical support has been provided to 10 Member States of that Region on how to promote rational use of medicines.

267. In the area of essential health technologies, there is now increased capacity in countries to manage health technologies including needs assessments, procurement, donations, maintenance and inventories. The WHO Secretariat is leading global efforts to bring medical devices to the attention of policy-makers and has led the development of a number of tools to support countries in ensuring improved access, quality and use of medical devices.

268. This Organization-wide expected result is considered as partly achieved, in particular the development and updating of essential medicines lists and therapeutic guidelines. Delays have occurred in the development and review of medicines lists because of the complexity of the process, the required analysis of evidence and the difficulty in obtaining consensus on the essential medicines to be selected from the various experts involved. The WHO Secretariat has also suffered from shortages of funds and a consequent reduction in human resources capacity, limiting achievements for normative work and for country support.

STRATEGIC OBJECTIVE 12

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

269. Four key challenges were addressed during the biennium: (a) enabling WHO to provide leadership in global health by reforming priority setting, governance, financing and management; (b) increasing effectiveness in the way WHO provides support to all Member States; (c) using WHO's convening power at global, regional and country level to reach agreement on key global health issues, in order to promote greater coherence among all development partners (particularly at country level), and to ensure the place of health in major global and regional forums; (d) using innovative technology and collaborative networks to make health-related information both more effective and accessible.

OWER 12.1

Effective leadership and direction of the Organization exercised through enhancement of governance, and the coherence, accountability and synergy of WHO's work.

Fully achieved

Indicator		Baseline	Target	Achieved
12.1.1	Proportion of documents submitted to governing bodies within constitutional deadlines in the six WHO official languages.	90%	95%	95%

270. WHO reform: The Director-General initiated a consultative process focusing on achieving better alignment between objectives agreed by the World Health Assembly and the resources available to finance their achievement. From this beginning in early 2010 a comprehensive Member State-driven programme of reform has evolved. The Sixty-fourth World Health Assembly endorsed the overall objectives of reform and mapped out a process of analysis and consultation leading to a special session of the Executive Board in November 2011. The Board at this session discussed three interconnected lines of work for reform, namely programme and priorities, governance, and management reforms. A Member State-driven process on criteria for priority setting, identified in consultation with Member States, will allow the Secretariat to develop an outline for the next General Programme of Work and Programme Budget 2014–2015 in time for the Sixty-fifth World Health Assembly in May 2012.

271. Global health governance: WHO's universal membership enables it to play a unique convening role in forging agreement on critical and often sensitive global health issues. In May 2011, after four years of difficult negotiation, the World Health Assembly endorsed a Pandemic Influenza Preparedness Framework, and its implementation. Other similar negotiations continue, for example on Spurious/falsely-labelled/falsified/counterfeit medicines. WHO has been active in global efforts to increase coherence among health and development partners, through monitoring progress against the indicators in the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action. WHO will continue in this role following the creation of the Busan Partnership for Effective Development Cooperation during the 4th High Level Forum on Aid Effectiveness in the Republic of Korea in November 2011, with its increasing focus on South–South and other forms of cooperation.

272. WHO has shaped health priorities in major global forums. In 2010, under the Canadian Presidency, health played a key role at the G8 summit. Health was also an important focus in the G8's work on accountability. Both lines of work were further developed following the 2010 United Nations General Assembly High Level meeting on the Millennium Development Goals, at which the Secretary General's Global Strategy "Every Woman and Every Child" was launched. WHO was subsequently asked to convene the Commission on Information and Accountability, which reported in May 2011, recommending an approach to monitoring the world's progress on maternal and child health that is now being implemented. In 2011, the High-level meeting of the United Nations General Assembly set a new international agenda on prevention and control of noncommunicable diseases.

OWER 12.2

Effective WHO country presence established to implement WHO country cooperation strategies that are aligned with Member States' health and development agendas, and harmonized with the United Nations country team and other development partners.

Fully achieved

Indicator		Baseline	Target	Achieved
12.2.1	Number of Member States where WHO is aligning its country cooperation strategy with the country's priorities and development cycle and harmonizing its work with the United Nations and other development partners within relevant frameworks, such as the United Nations Development Assistance Framework, Poverty Reduction Strategy Papers and Sector-Wide Approaches.	At least 145	33 of the 145 Country Cooperation Strategies updated/ revised	33 Country Cooperation Strategies[a]
12.2.2	Proportion of WHO country offices that have reviewed and adjusted their core capacity in accordance with their country cooperation strategy.	At least 50%	70%	77%

[a] A number of country cooperation strategies were extended to align the cycle with national plans/strategies and the cycle of UNDFs. Of the 33 country cooperation strategies, 10 are in the process of being updated/revised.

273. Technical and policy support for Member States. In addition to providing strategic guidance for WHO reform and other major policy issues, the Global Policy Group[1] provides a link between the Director-General, Regional Directors and Heads of WHO Country Offices, enhancing the coherence of WHO's support to individual Member States. Country cooperation strategies have been developed and updated in 144 countries, territories and areas where WHO has a physical presence. The country cooperation strategy is used: (i) to adjust the competency and skill mix of country offices to be in line with national policies, strategies and plans; and (ii) to inform WHO's planning process and better align technical support from regional offices and headquarters. An improved competitive process for selection, appointment and development of the Heads of WHO Country Offices, has contributed to enhancing WHO's leadership and capacity. The concept of country cooperation strategies will, in future, be used to define cooperation needs for all WHO Member States even where the Organization has no physical presence. The sixth global meeting of Heads of WHO Country Offices with the Director-General and Regional Directors provided staff with the necessary knowledge and skills related to the emerging health agenda, such as WHO reforms, noncommunicable diseases and universal health coverage.

OWER 12.3

Global health and development mechanisms established to provide more sustained and predictable technical and financial resources for health on the basis of a common health agenda which responds to the health needs and priorities of Member States.

[1] The group consists of the Director-General, Deputy Director-General and Regional Directors.

Fully achieved

Indicator		Baseline	Target	Achieved
12.3.1	Number of health partnerships in which WHO participates that work according to the best practice principles for Global Health Partnerships.	14	30	45
12.3.2	Proportion of health partnerships managed by WHO that comply with WHO partnership policy guidance.	100%	100%	100%[a]
12.3.3	Proportion of countries where WHO is leading or actively engaged in health and development partnerships (formal and informal), including in the context of reforms of the United Nations system.	71%	80%	80%

[a] WHA63.10 ensures that all WHO-hosted partnerships comply with WHO Rules and Regulations. By the end of 2011 a total of 10 partnerships hosted by WHO had a separate governance mechanism.

274. Global health partnerships and initiatives. Based on previous work by the Secretariat and reports to the Executive Board, in 2010, the World Health Assembly endorsed the policy on WHO's engagement with global health partnerships and hosting arrangements (resolution WHA63.10 and its Annex). The policy provides additional guidance to WHO, and ultimately to countries, to help harmonize global health and development mechanisms. Implementation of the policy also includes further definition of WHO rules and practices concerning partnerships through an operational framework. Advancing WHO's work in partnering with various sectors, for the first time, the Global Policy Group endorsed an internal WHO policy framework for private sector engagement beginning a process to add clarity on WHO's interaction with this sector.

OWER 12.4

Essential multilingual health knowledge and advocacy material made accessible to Member States, health partners and other stakeholders through the effective exchange and sharing of knowledge.

Fully achieved

Indicator		Baseline	Target	Achieved
12.4.1	Average number of page views/visits per month to the WHO headquarters' web site.	Not available/ 6.35 million visits/ month	6.7 million	7 million
12.4.2	Number of pages in languages other than English available on WHO country and regional offices' and headquarters' web sites.	70 495	80 000	More than 80 000

275. Enhancing access to health information. To enhance the dissemination of timely health information to all who need it, WHO has put in place a consistent technology base to link all WHO offices. Progress has been made through the creation of a web page for multilingualism. Work continued with external partners for translation of over 200 WHO publications into 40 official and non-official languages. A report on the implementation of the WHO publications policy was presented to the Executive Board at its 129th session (document EB129/4). The *Bulletin of the World Health Organization* was published once a month in multiple formats with abstracts in all official languages. More than 80 proposals for designation and 200 proposals for re-designation of WHO collaborating centres have been reviewed. The Guidelines Review Committee met on a monthly basis and reviewed the initial proposals for guideline development prior to their publication, as well as final submissions to ensure that the process and form of the recommendations followed WHO requirements. Pilot testing of a compendium of national expertise, designed initially in close collaboration with departments within headquarters and six regional offices, is under way as well as mapping of the existing databases and their assessment.

STRATEGIC OBJECTIVE 13

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

276. Effective and efficient administrative and management support services are critical to the delivery of the technical work of the Organization. The main challenge has been to provide good quality services whilst striving to achieve increased efficiencies. This is needed to offset increasing costs arising from multiple factors, notably, the impact of the strong Swiss franc on services at headquarters, and of the rapidly increasing cost of security for field staff, particularly in some countries in the African Region and the Eastern Mediterranean Region.

OWER 13.1

Work of the Organization guided by strategic and operational plans that build on lessons learnt, reflect country needs, are elaborated across the Organization, and used to monitor performance and evaluate results.

Fully achieved

Indicator		Baseline	Target	Achieved
13.1.1	Proportion of country workplans that have been peer reviewed with respect to their technical quality, that they incorporate lessons learnt and reflect country needs.	95%	95%	100%
13.1.2	Office-Specific Expected Results (OSERs) for which progress status has been updated within the established time frames for periodic reporting.	74%	85%	85%

277. Progress has been made in terms of improving the consistent planning and assessment of results across the Organization. In particular, the schedule for producing the Programme Budget Performance Assessment has been accelerated so that the report is presented to the World Health Assembly in May immediately following the completion of the biennium. In addition, the method of assessing the

achievement of country-based performance indicators now includes the identification and verification of individual countries.

278. Throughout the biennium, work has continued on improving the alignment between the priorities identified by individual Member States through country cooperation strategies and priorities identified in the programme budget and operational plans. Further improvements have also been made in relation to the results chain for the Organization, with the aim of making a clearer distinction between impacts, outcomes and outputs. Both of these areas are key elements of the WHO reform programme and will be central to the development of the next General Programme of Work and Programme Budget 2014–2015.

OWER 13.2

Sound financial practices and efficient management of financial resources achieved through continuous monitoring and mobilization of resources to ensure the alignment of resources with the programme budgets.

Partly achieved

Indicator		Baseline	Target	Achieved
13.2.1	Degree of compliance of WHO with International Public Sector Accounting Standards.	Compliance requires completion of introduction of the Global Management System in all regions	Systems and opening accounts fully compliant	Systems and opening accounts fully compliant
13.2.2	Amount of voluntary contributions that are classified as fully and highly flexible.	US$ 187 million	US$ 300 million	US$ 235 million

279. An unqualified audit opinion on the first biennial financial statement was produced under the General Management System; the enterprise risk management framework was institutionalized at headquarters and its expansion to the regions initiated. Preparations for the introduction of the new International Public Sector Accounting Standards (IPSAS) were completed. The first fully compliant IPSAS financial statements will be prepared for 2012.

280. Significant progress was also made in relation to the financial control framework. Of particular importance was the updating of WHO's electronic policy manual. This forms the platform for further work on standard operating procedures and key controls due for completion in 2012. In addition, an Independent Expert Oversight Advisory Committee was established and became a highly credible additional component of governance and oversight of financial and administrative functions.

281. This Organization-wide expected result was considered to be partly achieved because the target for voluntary contributions, which are classified as fully and highly flexible was not met. However, despite the constraints created by the financial crisis, the total amount of flexible resources raised increased from US$ 187 million received in 2008–2009 to US$ 235 million received in 2010–2011.

This is part of an overall trend in voluntary contributions towards multi-year agreements with a stronger focus on flexibility and predictability.

OWER 13.3

Human resource policies and practices in place to attract and retain top talent, promote learning and professional development, manage performance, and foster ethical behaviour.

Partly achieved

Indicator		Baseline	Target	Achieved
13.3.1	Proportion of offices with approved human resources plans for a biennium.	98%	100%	100%
13.3.2	Number of staff assuming a new position or moving to a new location during a biennium (delayed until biennium 2010–2011).	200	200	700
13.3.3	Proportion of staff in compliance with the cycle of the Performance Management Development System.	75%	80%	HQ and WPRO more than 90%

282. A difficult process to reduce headcount, notably in the African Region and at headquarters, due to budget cuts and staff cost increases, was managed through a highly inclusive process. This ensured that down-sizing was carried out fairly, with full communication and support to all concerned staff. This effort was aided by the improvement in human resources planning, especially in offices where the Global Management System was introduced over the biennium.

283. There was a significant increase in the movement of staff between and within duty stations. This was a result of a more systematic approach to movement of staff in the African Region and the Western Pacific Region, the use of the Global Roster for Heads of WHO Country Offices and the re-assignment of staff whose positions were abolished for programmatic and financial reasons.

284. Global learning remained a high priority. The range of global development opportunities has been expanded during the biennium, with priority given to country-level activities. Work to increase the use of e-learning and online learning management systems in the coming years has continued.

285. There has been improvement in performance management reviews of staff, in particular in headquarters and the Western Pacific Region, where more than 90% of performance assessments were completed, this Organization-wide expected result was assessed to be partly achieved because the overall target was not met in all regions. This issue is being addressed through the mandatory implementation of the updated version of the performance management and development system in all regions in 2012.

OWER 13.4

Management strategies, policies and practices in place for information systems, that ensure reliable, secure and cost-effective solutions while meeting the changing needs of the Organization.

Fully achieved

Indicator		Baseline	Target	Achieved
13.4.1	Number of information technology disciplines implemented Organization-wide according to industry-best-practices benchmarks.	3	5	5
13.4.2	Proportion of offices using consistent real-time management information.	Headquarters and the Western Pacific regional offices and associated country offices	Headquarters, 5 regional offices and associated country offices	Headquarters, 5 regional offices and associated country offices

286. The Global Management System has been implemented in all regional and country offices, apart from the Regional Office for the Americas/PAHO. The existence and use of a single integrated system has improved access to, and the transparency of, data, and allows real-time management of information. Preparations have been initiated for the first major upgrade of the Global Management System, scheduled for 2013.

287. A new "global synergy" platform was rolled out across the Organization, which will provide a single, common approach to workstation management across the Organization, facilitating user support, and information exchange.

288. The delivery of information and communications technology services continued to be moved to either the Global Service Centre in Kuala Lumpur or outsourced to external suppliers as a way of lowering costs and providing a more flexible service delivery model.

OWER 13.5

Managerial and administrative support services necessary for the efficient functioning of the Organization provided in accordance with service-level agreements that emphasize quality and responsiveness.

Partly achieved

Indicator		Baseline	Target	Achieved
13.5.1	Proportion of services delivered by the global service centre according to criteria in service-level agreements.	75%	90%	85%

289. Operations of the Global Service Centre have begun to run more smoothly as staff have become familiar with their role and with the Global Management System. The percentage of transactions processed according to published Service Level Indicators increased to 85%. This is despite a 40% rise in transactions as a result of the Eastern Mediterranean Region, the European Region, the South-East Asia Region and the African Region going live with Global Management System during the biennium. The unit cost for processing transactions has continued to decrease. Additional functions in finance

and procurement have been moved from headquarters to the Global Service Centre, further reducing the overall cost of administration.

290. The Organization-wide expected result was rated "partly achieved" due to a combination of system and/or procedural inefficiencies in some service areas. Work is continuing across all three levels of the Organization to improve the service levels and the end-to-end administrative processes whilst retaining an adequate control framework.

OWER 13.6

Working environment conducive to the well-being and safety of staff in all locations.

Partly achieved

Indicator		Baseline	Target	Achieved
13.6.1	Degree of satisfaction with quality of services in all major offices resulting from effective infrastructure support services.	Not available	75%	Not Available[a]
13.6.2	Proportion of offices that have conducted regular building evacuation exercises.	70%	70%	90%

[a] Indicator 13.6.1 is being discontinued and is replaced in 2012–2013.

291. In all countries, enhanced security was achieved through upgrades to country office facilities in vulnerable locations and security evaluations that focus on compliance with United Nations standards. In the Eastern Mediterranean Region, many staff had to be evacuated from their duty stations, including staff from the Regional Office in Cairo. These evacuations were implemented successfully with the support of the Security Fund, established to meet such emergencies. Overall security costs continue to rise as a result of the increasingly stringent criteria for security established by the United Nations.

292. Efforts to mitigate the impact of the Offices on the immediate environment and to introduce further cost-containment measures continued. For example, the introduction of the managed print and copy services at headquarters has reduced the cost of office printing and copying in 2010–2011 from 7.2 million Swiss francs to 5 million Swiss francs and has contributed to a 50% reduction in paper consumption.

293. A new governance mechanism was introduced for the evaluation and oversight of major capital investment projects. In parallel, for capital financing, a sustainable funding source was introduced (through the post occupancy charge), although the amounts raised continue to be lower than the amounts needed for a steady investment of 1% of existing capital value. Because of this a number of infrastructure projects have been postponed resulting in this Organization-wide expected result being assessed as "partly achieved". However, regular maintenance has been undertaken in all offices to ensure that core infrastructure services are maintained to acceptable standards.

= = =