

Implementation of Programme budget 2010–2011: interim report

Report by the Secretariat

1. Implementation of the Programme budget 2010–2011 across the Organization was reviewed at the mid-term of the biennium. The mid-term review process examines progress made towards the achievement of expected results to 31 December 2010, including the Organization-wide expected results set out in the Programme budget 2010–2011. In addition, it focuses on impediments, risks, success factors, lessons learnt, and actions required to improve progress. Budget implementation was also reviewed, allowing for simultaneous consideration of programmatic and financial implementation.¹
2. The risks, impediments and problems identified enable senior managers to devise the necessary corrective actions. The review allows re-programming and allocation or reallocation of resources, and preparation of the Proposed programme budget 2012–2013 and its associated workplans.
3. As in previous bienniums, the current mid-term review was a self-assessment exercise in which major offices indicated whether their respective contributions to the expected results were on track. Progress ratings reflect the extent to which programmes have delivered their outputs and performance indicators have been achieved. The lessons learnt and actions required to improve progress were documented at each level. Peer review and quality assurance were built into the process so as to ensure that progress was assessed in a focused and consistent manner.
4. In January 2011, the Executive Board noted the update on implementation of Programme budget 2010–2011,² which contained analyses and projections and indicated some of the measures being taken by the Secretariat in the light of the current financial situation.
5. The mid-term review identified the outcomes that should be prioritized and the areas at risk of shortfalls in funding. The Global Policy Group will use such information in decisions it takes during the second half of the biennium in response to the financial situation.

¹ See document A64/29, Unaudited interim financial report on the accounts of WHO for the year 2010.

² See document EB128/2011/REC/1, summary record of the seventh meeting, section 2.

OVERVIEW OF ORGANIZATION-WIDE EXPECTED RESULTS

6. Table 1 shows the progress made in achieving the Organization-wide expected results by strategic objective.¹ An “on track” rating implies that the rate of progress has been as foreseen up to the mid-term and that it is not likely to be significantly altered during the rest of the biennium. In general, for an expected result to register an “on track” rating, at least six of the seven major offices would have reported appropriate progress. An “at risk” rating means that progress towards achieving the relevant Organization-wide expected results is being affected by impediments and risks for which corrective action is required. If the contributions of two or more of the seven major offices have an “at risk” rating this potentially calls into question the achievement of those results across the Organization. An “in trouble” rating implies that progress is being seriously hampered and it is likely that the Organization-wide expected result will not be achieved.

7. In case there should be a funding shortfall during 2011, those Organization-wide expected results that are considered to be of the highest priority and are currently on track will be protected, as will a subset of results rated as being at risk. All “at risk” expected results have been considered for follow-up actions. Work on Organization-wide expected results that are “in trouble” may be cut back or postponed until the next biennium. Particular attention has been focused on the reasons why progress is not on track and the actions required to minimize the risk to full achievement of expected results by the end of 2011.

8. Out of a total of 85 Organization-wide expected results for the biennium 2010–2011, 59 were considered to be “on track” and 26 “at risk”. Progress ratings vary significantly between strategic objectives (Table 1), with half or more of the Organization-wide expected results for strategic objectives 4, 10 and 11 being rated as “at risk”.

Table 1. Progress rating by strategic objective

Strategic objective		Organization-wide expected results			
		On track	At risk	In trouble	Total
SO 1	To reduce the health, social and economic burden of communicable diseases	6	3	0	9
SO 2	To combat HIV/AIDS, tuberculosis and malaria	4	2	0	6
SO 3	To prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment	6	0	0	6
SO 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	3	5	0	8

¹ A detailed report of progress to the mid-term by strategic objective is available and will be provided on request.

Strategic objective		Organization-wide expected results			
		On track	At risk	In trouble	Total
SO 5	To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact	5	2	0	7
SO 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	6	0	0	6
SO 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	4	1	0	5
SO 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	6	0	0	6
SO 9	To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development	5	1	0	6
SO 10	To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research	4	9	0	13
SO 11	To ensure improved access, quality and use of medical products and technologies	1	2	0	3
SO 12	To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system, and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work	4	0	0	4
SO 13	To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively	5	1	0	6
Total		59	26	0	85

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

9. Trends related to global vaccination coverage (as measured by estimates of administration of three doses of diphtheria-tetanus-pertussis vaccine) continued to be positive; the number of countries reaching 90% or more immunization coverage continues to increase, even though estimated global coverage was maintained at 82%. The progress of the Global Polio Eradication Initiative in 2010 is dominated by four strong results: the number of cases of poliomyelitis were reduced by more than 97% in Nigeria and by more than 94% in India; the lowest levels of detection of wild poliovirus type 3 in the programme's history (84 cases in 2010 compared with 1073 in 2009); and the interruption of importation of wild polioviruses in 16 of the 19 countries where the viruses had been detected anew in 2009 owing to either new outbreaks or re-established transmission. WHO in 2010 published its first report on neglected tropical diseases.¹ A new meningitis vaccine, developed with a public-private partnership model, was registered and WHO-prequalified, and its introduction launched in the African meningitis belt. Rotavirus and conjugate meningitis A vaccines were introduced following successful clinical trials in the African Region. A simplified system of dengue case classification was developed through a multicentre prospective clinical study, evaluated in 18 countries and adopted and used throughout Latin America and increasingly through Asian countries.

10. Throughout 2010, headquarters ensured continued support to the Emergency Committee until the pandemic (H1N1) 2009 was declared over. Global response and surveillance continue to be strengthened for all communicable diseases, both through existing networks as well as through joint activities with the regions and Member States. The global event management system is on track to exceed its indicator target, with 481 users at 148 WHO sites. The Secretariat has responded to all Member States' requests for emergency assistance under the International Health Regulations (2005), through headquarters' technical resources, diverse specialist networks, and the institutions of the Global Outbreak Alert and Response Network. In 2010 actions were taken in response to outbreaks of, for example: pandemic influenza; dengue in Cap Verde; suspected viral haemorrhagic fever in the Democratic Republic of the Congo and Uganda; cholera in Haiti; Rift Valley fever in South Africa; dengue/Crimean-Congo haemorrhagic fever/cholera in Pakistan; meningitis and yellow fever in Cameroon, the Central African Republic, Chad, Côte d'Ivoire, the Democratic Republic of the Congo, Ghana, Guinea, Niger, Nigeria and Sudan; and plague in Peru.

11. Despite serious financial constraints, six of the nine Organization-wide expected results are assessed as "on track". Three are assessed as "at risk". In the area of poliomyelitis eradication (Organization-wide expected result 1.2), significant challenges remain to achieving the goal globally, particularly in implementing high-quality mop-up campaigns required to stop low-level transmission in historic reservoirs. In the area of alert and response systems for use in epidemics and public health emergencies (Organization-wide expected result 1.6), two regions reported their contributions as "at risk" owing to difficulties in assessing and developing national core capacities under the International Health Regulations (2005). In the area of response to epidemics and public health emergencies, Organization-wide expected result 1.8 is rated as "at risk" by three regions on account of major obstacles to reaching the national core capacity targets established by the International Health Regulations (2005). Enhanced resource mobilization efforts are planned at every level.

¹ *Working to overcome the global impact of neglected tropical diseases*. Geneva, World Health Organization, 2010.

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

12. Member States continued to make progress in expanding access to HIV, tuberculosis and malaria prevention, diagnosis, treatment and care. WHO contributed by issuing updated policy guidance, stepping up its technical support and capacity-building activities, and monitoring and evaluation. In the area of HIV, guidelines were developed or updated, including those for antiretroviral therapy in adults and children, prevention of mother-to-child transmission of HIV, infant feeding, and HIV-associated tuberculosis. The draft global health sector strategy for HIV/AIDS 2011–2015 was prepared for consideration by the governing bodies. The results of WHO's work on tuberculosis included review and guidance on the use of a new diagnostic test that could revolutionize care and control through faster diagnosis, reduced transmission and earlier access to treatment, especially for people with multidrug-resistant tuberculosis and HIV-associated tuberculosis. The Global Malaria Programme defined its five-year strategy, and published new treatment guidelines that included a major new policy recommendation on universal diagnostic testing of cases of suspected malaria before treatment. Working with major partners, the Secretariat supported Member States in accessing new diagnostics, medicines and other products, and adopting innovative approaches in order to reach more people at risk worldwide. WHO's global reports presented the latest data on the state of the epidemics of HIV, tuberculosis and malaria and the nature, scale and impact of the response. WHO produced special reports on drug-resistant tuberculosis and artemisinin-resistant malaria.

13. Four of the six Organization-wide expected results are assessed as being “on track” and two as “at risk”: Organization-wide expected results 2.1 and 2.6. The former relates to implementation of WHO policies, and not just their development and adoption. Therefore, although overall the Organization is on track in its normative and policy work at global level in most regions, its capacity to support full adoption and implementation of policies is at risk because of resource and capacity constraints. For example, adoption of new WHO guidance on earlier timing of initiation of antiretroviral treatment of HIV infection will require intensive efforts by Member States to update and implement their policies. For expected result 2.6 (new knowledge intervention tools and strategies) the African and South-East Asia regions indicate that a lack of capacity is hampering their ability to make rapid progress in promoting research and related products.

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

14. Evidence-based guidance for cost-effective prevention of heart attacks and strokes was developed and a multiple risk factor approach for cardiovascular risk management has been adopted by Member States in all WHO regions. The diagnostic criteria for myocardial infarction and diabetes have been reviewed, taking into consideration their applicability within weak health systems in low- and middle-income countries. The new mental health Gap Action Programme's intervention guide on mental, neurological and substance use disorders for non-specialist health settings and a manual on preventing intimate partner and sexual violence against women were issued. Data on mental health indicators are currently being collected through the 2010 Mental Health Atlas project. Updated figures on the number of Member States that report basic mental health indicators annually will be available by the end of 2011. A collection of case studies in trauma care was published in order to raise awareness of affordable ways in which trauma- and emergency-care services can be strengthened. Guidelines for community-based rehabilitation were published, providing an important tool for programme managers to meet the basic needs and enhance the quality of life of people with disabilities. WHO, in collaboration with the United Nations regional commissions and other partners, prepared a plan of action for the Decade of Action for Road Safety 2011–2020, as requested in United

Nations General Assembly resolution 64/255. The plan provides national and local governments with a guiding document for the preparation of action plans for 2011–2020.

15. Despite financial and human resource limitations, some notable results were achieved in 2010. On balance across the major offices, all six Organization-wide expected results are on track. Constraints in technical capacity due to lack of sufficient staffing put specific work areas at risk in different regions. For example, publications on evidence on the cost-effectiveness and cost/benefit ratios of interventions for chronic noncommunicable conditions may be delayed, and work in support of development and inclusion of disability indicators in national health reporting systems and annual reports is lagging behind. Advocacy by WHO and partners on the health issues covered under this strategic objective has had a noticeable impact.

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

16. Progress was made in crucial action areas towards the attainment of the Millennium Development Goals 4 (Reduce child mortality) and 5 (Improve maternal health) and particular emphasis was placed on integrated service delivery and approaches to removing barriers to essential services for reproductive, maternal, child and adolescent health. The Campaign for Accelerated Reduction of Maternal Mortality was launched in 21 African countries, and 16 countries in the African Region have undertaken a mid-term review of their road maps for the reduction of maternal mortality. Support has been provided to countries in all regions for improving skills of health-care providers on newborn care through WHO's Essential Newborn Care Course, and the African and Western Pacific regions have introduced care for newborns at home. Good progress has been made in building the capabilities of national experts in operational research in reproductive health, thereby contributing to the overall implementation of the reproductive health strategy. In order to increase access to essential care of sick children, three regions have introduced and integrated care of children in the community. A systematic review on prevention of early pregnancy was completed and will be translated into guidelines for action in countries in 2011. The WHO Global Network of Age-friendly Cities was established and a SharePoint site constructed.

17. Three of the eight Organization-wide expected results are "on track", but five are rated as "at risk". Although Organization-wide expected result 4.3 (maternal care) is a priority area, a lack of resources has limited the support provided by WHO, especially in the African Region, for improving quality of care during child birth and in the postnatal period. With regard to Organization-wide expected result 4.5 (improving child health), the application of guidelines and tools for child health, and the generation and monitoring of strategic information for newborn, child and adolescent health are "at risk". Organization-wide expected result 4.6 (adolescent health) has been particularly affected by a lack of resources for providing systematic support to countries, particularly for adolescent-friendly health services. For Organization-wide expected result 4.7 (reproductive health), the delivery of products supporting the development of programmes to improve sexual and reproductive health, such as clinical, managerial and programmatic guides, has been affected by reduced funding. Despite having made gradual progress, the area of ageing (Organization-wide expected result 4.8) is assessed as being "at risk" for the duration of the biennium owing to the risk that some countries, specifically in the African and Western Pacific regions, will not achieve the target on having a functioning active healthy ageing programme consistent with resolution WHA58.16 on strengthening active and healthy ageing.

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

18. Progress was made in developing country capacity in risk reduction and emergency preparedness including the introduction of the Hospital Safety Index in priority countries and the initiation of vulnerability and risk assessment mapping. Health emergency management was integrated into guidance to countries on national health planning and in country cooperation strategies. Standard operating procedures were enhanced to enable a rapid WHO response. Surge capacity was strengthened for more rapid deployment of funds, supplies and human resources. As lead agency of the health cluster, WHO worked in support of Member States to lead the overall joint national and international response to acute crises such as the earthquake in Haiti and the flooding in Pakistan and also to ongoing complex emergencies in Afghanistan, Benin, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Guinea, Haiti, Kyrgyzstan, Liberia, Niger, Nigeria, Pakistan, Uzbekistan and Zimbabwe. This support included work in strategic planning, deployment of staff, assessments, technical guidance, development of coordinated multi-agency action plans and provision of emergency medical supplies. Early warning and surveillance systems for communicable diseases were strengthened. Member States' preparedness and response mechanisms for food safety and environmental health emergencies were strengthened and participation in relevant early warning networks widened. Post-disaster and post-conflict needs assessments and analysis of disrupted health systems benefited from technical developments.

19. Five of the seven Organization-wide expected results are "on track" and two are rated as "at risk". Organization-wide expected result 5.5 (food safety and environmental health emergencies) is rated as "at risk" because of insufficient resources in the Region of the Americas and the Eastern Mediterranean Region: the Eastern Mediterranean Regional Office specifically cited the lack of funds to hire the required staff. Implementation of Organization-wide expected result 5.7 (outbreak and crisis response) is "at risk" in the European Region because of delays in both receiving funds and recruiting health cluster coordinators; and in the Eastern Mediterranean Region because of the open-ended nature of chronic emergencies that has led to donor fatigue; it should be noted that headquarters cited a lack of capacity in terms of the necessary human resources to respond to technological emergencies. Nevertheless, the Secretariat has managed to mobilize coordinated action in most crises and to implement action plans with partners in most chronic emergency situations.

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

20. WHO provided technical support for developing health-promotion policies and plans at country level. By late 2010, 82 countries were using the WHO STEPwise approach in order to develop monitoring systems and surveys for noncommunicable disease risk factors in their adult populations. Twenty-six cities were implementing the Urban Health Equity and Response Tool; data and experience gathered through the pilot-testing phase and development of the tool in several cities provided a useful insight for identifying crucial opportunities to fill gaps in the area of urban health metrics, and highlighted the importance of intersectoral action for health to tackle urban health inequities. Significant advances were made in the implementation of the WHO Framework Convention on Tobacco Control at country level, and in securing approval for several treaty tools. By the end of 2010, 172 Member States had become Parties to the Convention. Thirteen countries had undertaken Global Adult Tobacco Surveys and 160 countries had completed Global Youth Tobacco Surveys.

21. In conjunction with World No Tobacco Day 2010, a monograph was published on the epidemic of tobacco among women. The Secretariat worked directly to increase the efficiency and effectiveness of tobacco tax systems, resulting in increased tobacco taxes in five countries. In 25 countries, tobacco taxes represented more than 75% of the price of cigarettes. In 29 countries 100% smoke-free legislation was approved. Forty-one countries adopted graphic health warnings on more than 30% of the package surface. The Sixty-third World Health Assembly endorsed both the Global strategy to reduce the harmful use of alcohol (resolution WHA63.13) and a set of recommendations on marketing foods and non-alcoholic beverages to children (resolution WHA63.14). A regional strategy to reduce the harmful use of alcohol was approved for Africa. Significant progress was made with alcohol monitoring and surveillance by finalizing analysis of data on alcohol consumption, alcohol-related harm and policy responses for all Member States and preparing for publication the global status report on alcohol and health. Further work was done on alcohol-related indicators for surveillance. Technical tools related to population-based prevention of childhood obesity and population salt-reduction strategies were developed through a series of technical meetings and information exchange forums. A special tool for surveillance of unsafe sex, its determinants and consequences using the STEPwise approach was finalized.

22. Overall, all six Organization-wide expected results are “on track”. However, as financial resources are insufficient across the Organization, some activities relating to health promotion and capacity building at country level to implement the WHO Framework Convention on Tobacco Control and the Global strategy to reduce the harmful use of alcohol could be delayed or only partly achieved by the end of the biennium. Increased efforts are required to ensure that sustained surveillance systems of noncommunicable diseases are resourced and implemented within countries. In providing technical assistance to Member States to make progress on the implementation of the WHO Framework Convention at country level, the Secretariat is conscious of the activities of the tobacco industry to try to undermine public health. Therefore, it is developing a technical resource to increase capacity to deal with the industry’s undermining activities in light of some aggressive behaviour against some Member States, such as Uruguay.

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

23. A regional strategy to address key determinants of health in the African Region was endorsed.¹ Technical assistance for implementation of activities on the social determinants of health and equity-focused health was provided to 18 countries in three regions. Evidence on implementation of activities in countries was generated and analysed and will be presented at the World Conference on Social Determinants of Health in October 2011. Guidance materials on the implications of certain trade-related aspects of intellectual property rights, and the implications of international trade and trade agreements for health, were developed as support for Member States. Targeted capacity building on health and human rights was provided to more than 10 countries and selected regional stakeholders, such as the Economic Community of West African States. Assessment tools and guidance materials on a human rights-based approach to health were developed and disseminated. WHO was reconfirmed as the permanent secretariat of the Global Summit of National Ethics Committee, which contributes to the dissemination and implementation of the WHO guidance document on ethics of tuberculosis prevention, care and control. WHO played a leading role in high-level global consultations on essential ethical issues including in the United Nations Interagency Committee on Bioethics. WHO’s

¹ Resolution AFR/RC60/R1.

global leadership on women's health and gender was strengthened through the policy dialogue on women's health, and the ministerial leadership meeting on women and health.

24. Overall, four Organization-wide expected results are "on track". The fifth, Organization-wide expected result 7.3 (social and economic data relevant to health), is rated as "at risk" because of a lack of demand for technical support from Member States. Changes are required in the budget to allow for an increase in the allocation for Organization-wide expected result 7.4 (human rights and ethics). The increasing demand for country work on priority public health conditions to address the social determinants of health and health equity within public health programmes will require more resources. Strong leadership and commitment to funding fully the budget for Organization-wide expected result 7.5 (gender responsiveness) will be required.

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

25. The normative work on environmental threats to public health continued, for example, on chemical and radiation hazards, and air and water quality. Significant progress has been made in all areas of work on climate change and health. Consideration of health in the United Nations climate change process has been greatly increased, and a new contact group between interested country delegates, nongovernmental organizations and the United Nations system has been established. WHO has taken on the role of coordination of a cross-United Nations group on Social Dimensions of Climate Change. In the area of health system strengthening, a global project on health adaptation to climate change was initiated. Ministerial conferences on health and environment were convened for countries in Africa, Europe and South-East and East Asia, with priorities for action being agreed regionally. The Secretariat began to provide technical support to countries for managing health benefits and risks from extractive industry projects.

26. Overall, all six Organization-wide expected results are "on track". However, because of financial constraints, some activities pertaining to water resources and health, namely, health-impact assessment and environmental management, will have to be deferred. In the African Region, the number of countries funded to initiate implementation of the Libreville Declaration on Health and Environment (in which countries agreed to establish a health and environment strategic alliance as the basis for plans of joint action) is likely to be reduced.

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

27. In response to the mandate of the Health Assembly (resolution WHA63.23 on infant and young child nutrition), the Secretariat has been formulating a comprehensive implementation plan on the subject, with effective health interventions with an impact on nutrition, to be delivered through the health sector. These include behavioural change interventions in communities and health facilities, provision of micronutrient supplements in children, adolescents and women, targeted nutritional support, and nutritional support in emergencies. The plan also includes advocacy of non-health interventions with an impact on nutrition relating for example to agriculture and food production, social protection, trade, education, labour and information. In addition, the regional strategy on

nutrition 2010–2019¹ has been endorsed by the Regional Committee for the Eastern Mediterranean and a resolution has been approved by the Directing Council of the Pan American Health Organization,² endorsing the Strategy and approving the Plan of Action for the Reduction of Chronic Malnutrition. Also in response to a request from the Health Assembly (resolution WHA63.3 on advancing food safety initiatives), the Secretariat has worked on the implementation of the global food safety strategy including providing technical assistance and tools, promoting research and building relevant capacities in countries. The International Food Safety Authority Network has now 177 members. A Nutrition Guidance Expert Advisory Group was established, together with three subgroups on micronutrients, nutrition in the life course and malnutrition, and diet and health monitoring and evaluation. In the area of food safety, numerous reports providing scientific advice were issued in 2010, and the direct link to Codex Alimentarius Commission standard setting was improved, with 349 standards developed. Implementation of the WHO growth standards is progressing and 147 countries have now adopted them.

28. Although five of the six Organization-wide expected results are on track, the Regional Office for Africa may not be able to provide the necessary support to all countries for assessing needs and policy responses for nutrition and food safety owing to inadequate human resources at country level for Organization-wide expected results 9.3 and 9.6. For the same reason, the South-East Asia and Western Pacific regional offices might not be able to provide technical support to the development of policies and programmes in food safety (Organization-wide expected result 9.5).

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

29. Staff of 25 country offices have been trained and have developed road maps for improved support, in line with the national planning cycle in the countries they serve. Progress in health system performance assessment has been significant in 26 countries. Following the publication of *The world health report 2010* on universal coverage and health system financing, more than 61 countries have requested and received technical support from the Secretariat but the demand continues to exceed supply. Initiatives and investments in 41 countries experiencing a human resources for health crisis have been undertaken by WHO and partners including the Global Health Workforce Alliance. These country-level initiatives strengthen planning and policy-making for human resources for health through better data, retention strategies, intersectoral alliances and training of managers, among others. WHO observatories enhanced their capacity to monitor the health situation and trends in high-priority public health topics. All regions continued to work with Member States to ensure compliance with the recommendation to dedicate at least 2% of health budgets to research. The Health InterNetwork Access to Research Initiative (HINARI) is making progress as it develops and extends to more institutions worldwide. Most of the countries (40 out of 105) benefiting from HINARI are in the African Region. The 2009 global survey on e-health was completed with the participation of 114 Member States and the results published in December 2010. A unified health model for assessing the cost and impact of expanding health interventions is in the last stage of development. Some 40 revised tools for WHO Guidelines on Hand Hygiene were finalized and 12 000 hospitals in 123 countries were registered for the Hand Hygiene programme. The African Partnerships for Patient

¹ Resolution EM/RC57/R.4.

² Resolution CD.50.R11.

Safety was implemented in six countries in the African Region and the International Classification for Patient Safety was developed.

30. Overall, four of the 13 Organization-wide expected results are on track and nine are rated as “at risk”. Generally, for each of the 13 Organization-wide expected results, the targets have been achieved. However, the increasing demand for best practice evidence and technical assistance to countries as a result of their increased awareness of the vital importance of health systems has run far ahead of the needed investments to meet this demand. Furthermore, the lack and unpredictability of resources and the consequences for an already overburdened Secretariat staff in headquarters, regions and countries have contributed to the “at risk” rating for nine Organization-wide expected results. For Organization-wide expected results 10.1 (health-service delivery), 10.2 (governance and leadership) and 10.3 (coordination of mechanisms), engagement with countries is labour-intensive, painstaking and needs adept coordination with various players at country level. Specifically, the area of country planning and strategy and the funding mechanisms for better aid effectiveness need close attention. The demand for WHO’s technical assistance outstrips what the Organization can provide. Similarly, by the end of the biennium, it is uncertain if the core function of coordination of health system research (Organization-wide expected result 10.6) can be sustained owing to a lack of financial resources and other capacity constraints. Indicator 10.6.2 (2% of health budget for research) could also fail to be achieved as control over the health budget lies with countries and the Secretariat may not have much influence. A lack of funding for promotion of the WHO Global Code of Practice on the International Recruitment of Health Personnel (Organization-wide expected result 10.8) may jeopardize promotion and implementation of the Code at the country level. For Organization-wide expected result 10.9, although 21 out of the 57 countries with crises in human resources for health have developed relevant plans, lack of sustainable investments at country level combined with a reduced Secretariat capacity to provide technical assistance for critical country planning will impede the amelioration of the crisis in these countries. Although globally Organization-wide expected result 10.10 (health-system financing) appears to be on track in terms of countries supported, the African Region, the Region of the Americas and the Eastern Mediterranean Region report that financial constraints and limited capacity to respond to increasing demand, triggered partly by *The world health report 2010*, may prevent their achieving the targets. Organization-wide expected results 10.11 (estimating the economic consequences of illness) and 10.12 (health-financing policy) could only be partly achieved because of financial constraints and the inability of the Secretariat to keep up with increased demand.

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

31. The vaccine prequalification procedure was revised in 2010. The national regulatory agencies in 13 countries were assessed and all 12 countries in the Global Network for Post-Marketing Surveillance of Newly Prequalified Vaccines received financial and technical support to help to strengthen countries’ capacities to monitor the safety of vaccines used in their immunization programmes. An assessment of the structure and performance of the regulatory agency in 26 countries in Africa was completed. Standardized country profiles for the pharmaceutical sector are jointly being prepared by WHO, the World Bank and the Global Fund to Fight AIDS, Tuberculosis and Malaria in 73 low- and middle-income countries. More than 85% of antiretroviral and/or artemisinin-based combination therapies procured by the large funding agencies are procured from prequalified sources, with less than 3% failing to meet required quality standards. The WHO Model Formulary 2010 was issued, covering all essential medicines on WHO’s Model List of Essential Medicines, which is used by national formularies. The first Global Forum on Medical Devices brought together stakeholders to share knowledge on available medical device resources, guidelines, tools, strategies, policies and best

practices, and to determine the needs for the future. The Prequalification of Diagnostics Programme became fully operational with the first diagnostic product prequalified.

32. One of the three Organization-wide expected results is on track and two are rated as “at risk”. Organization-wide expected results 11.2 (international norms, standards and guidelines) and 11.3 (evidence-based policy guidance) are at risk because global quality standards for vaccines, medicines and essential technologies and normative programmes, such as the medicine safety and pharmacovigilance programme, WHO’s work against counterfeit medical products,¹ and work on quality norms for blood and blood products, are being implemented with reduced capacity and are underfunded. Promoting the rational use of medicines and combating antimicrobial resistance is also a severely underfunded area, despite its potential medical and economic benefits and the recent adoption by the Health Assembly of resolutions on the subject.²

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

33. Regular convening of the Global Policy Group increased organizational coherence. Discussions on the future of financing for WHO were launched in consultation with Member States and subsequent proposals for developing a WHO reform programme were prepared. In addition to organization of WHO’s governing bodies meetings, the Secretariat supported the Open-ended Working Group of Member States on Pandemic Influenza Preparedness, the consultation with Member States on Public Health Innovation and Intellectual Property, the Consultative Expert Working Group on Research and Development: Financing and Coordination, and the meetings of the International Health Regulations Review Committee.

34. Through renewed country cooperation strategies, WHO’s technical collaboration in countries in all regions has been increasingly aligned with national strategies and priorities. At regional level, policy and strategic consultations regularly took place between Regional Directors and Heads of Country Offices, further enhancing policy coherence across the three levels of the Organization. Heads of WHO Country Offices were selected from the global roster of successful candidates through a competitive selection process. The exchange of experiences in the context of harmonization and alignments and implementation of the principles of the Paris Declaration on Aid Effectiveness was facilitated by regional offices, enabling learning among peers between the country teams.

35. The work on global health and development mechanisms resulted in the endorsement by the Health Assembly of the policy on WHO’s engagement with global health partnerships and hosting arrangements (resolution WHA63.10) and the Global Policy Group’s endorsement of WHO’s policy framework for private sector engagement. Regional offices actively participated in a peer support group, within the framework of the regional United Nations Development Group and Regional Directors team, in order to provide technical support to United Nations Country Teams for the United Nations Development Assistance Framework development process. Multilingual versions of major

¹ The term “counterfeit” is used to refer to substandard/spurious/false-labelled/falsified/counterfeit medical products.

² Resolutions WHA58.27 and WHA60.16.

publications were produced and the multilingual content of web sites of all major offices was enhanced. Access to scientific and technical literature was maintained for all WHO staff.

36. All four Organization-wide expected results are rated as “on track”. Regular monitoring of the technical and financial situation at regional and budget centre level will ensure the optimal use of funds. The strategic objective is under severe financial pressure mainly due to the high cost of the numerous intergovernmental processes.

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

37. In 2010 the Secretariat completed the introduction of the Global Management System to all locations except the Region of the Americas, which has decided not to implement it. The System is facilitating greater consistency in service delivery and improved transparency and reporting across the Organization, for example improved financial management reporting and income analysis. This improvement was evidenced in an unqualified audit opinion on first biennial Financial Statement produced in the new system environment. During 2010 the draft Proposed programme budget 2012–2013 was prepared and discussed at regional committees (as well as by the Programme, Budget and Administration Committee in January 2011). The Programme Budget Performance Assessment 2008–2009 with its improved assessment of indicators was noted by the Sixty-third World Health Assembly, and the interim assessment of the Medium-term strategic plan 2008–2013 was conducted with participation of Member States.¹ A global resource mobilization strategy was endorsed by the Global Policy Group.

38. Funding mechanisms for the Capital Master Plan and security requirements were identified and adopted by the Sixty-third World Health Assembly (resolutions WHA63.6 and WHA63.7). The Secretariat supported the work of the new Independent Expert Oversight Advisory Committee. Other key achievements include the implementation of a cost-recovery mechanism through a post-occupancy charge, a global roster for the heads of country offices with proposals for development of further global rosters for other generic positions, and the institutionalization of the enterprise risk management framework at headquarters in the general management area and initiation of its expansion to the regions.

39. Five of the six Organization-wide expected results are on track. Only Organization-wide expected result 13.5 (managerial and administrative support services) is rated “at risk”. Interactions and coordination between the Global Service Centre and regional and country offices have improved through more focused communications and joint problem solving. However, difficulties remain in some service areas due to a combination of system and/or procedural inefficiencies, and work is ongoing across all three levels of the Organization to improve the service levels and functionality of the end-to-end administrative processes whilst retaining an adequate control framework.

¹ Document A64/6.

OVERVIEW OF BUDGET IMPLEMENTATION BY THE END OF 2010

40. In January 2010, the Executive Board noted the immediate funding challenges facing WHO, especially as a result of the potential gap between projected income and expenditure and the projected decline in income from voluntary contributions, which are estimated to be between 10% and 15%.

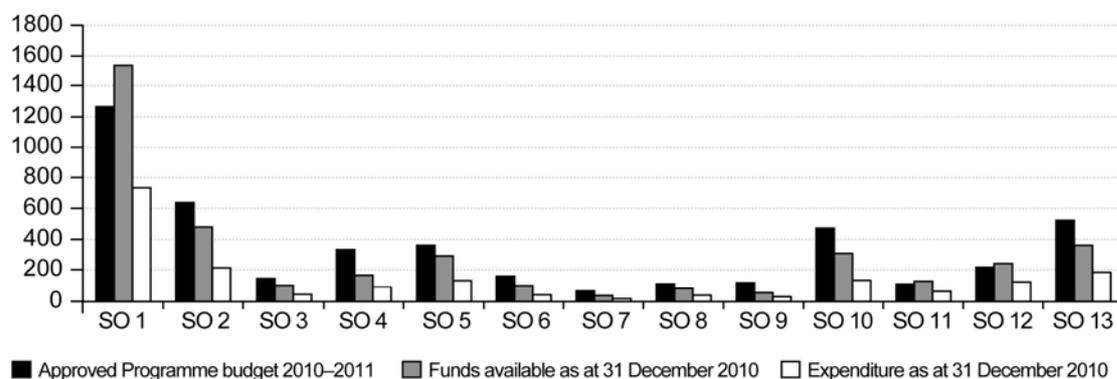
41. The mid-term review shows that some strategic objectives and major offices are relatively well-resourced while others face substantial shortfalls. A redistribution of the available resources would allow a closer alignment with the Programme budget, but WHO is severely constrained by the specificity of the funding available and the unevenness of its distribution among budget segments, both of which limit flexibility to reallocate funds between strategic objectives or major offices.

42. The following tables show how the Programme budget 2010–2011 has been implemented to 31 December 2010 by strategic objective, budget segment and major office.

**Table 2. Financial implementation by strategic objective
(US\$ million as at 31 December 2010)**

Strategic objective	Approved budget 2010–2011	Funds available as at 31 December 2010			Funds available as % of approved budget	Expenditure as at 31 December 2010	Expenditure as % of approved budget	Expenditure as % of funds available
		Assessed contributions	Voluntary contributions	Total				
SO1	1 268	73	1 462	1 535	121	737	58	48
SO2	634	40	440	480	76	217	34	45
SO3	146	37	61	98	67	40	28	41
SO4	333	46	124	170	51	88	27	52
SO5	364	15	276	291	80	136	37	47
SO6	162	31	64	95	59	44	27	47
SO7	63	15	20	35	56	16	25	45
SO8	114	30	55	85	74	37	33	44
SO9	120	18	39	58	48	27	23	48
SO10	474	124	183	307	65	136	29	44
SO11	115	26	99	125	109	65	56	52
SO12	223	190	55	246	110	129	58	52
SO13 ^a	524	279	85	364	69	189	36	52
Not yet distributed to strategic objectives			29	29				
Total	4 540	925	2 993	3 918	86	1 862	41	48

^a As well as the approved programme budget figure shown for strategic objective 13 in Table 2, an additional US\$ 58 million of related costs are financed through a separate cost-recovery mechanism under strategic objective 13 bis (see summary table 6, Proposed programme budget 2010–2011, and further elaborated in the full document “Implementation of Programme budget 2010–2011, Mid-term review” (document WHO/PRP/11.1) in English only and available on request). These costs are included in Table 2 against all strategic objectives, which contribute to the financing through the post occupancy charge to recover costs of administrative services directly attributable to the work of these strategic objectives.



WHO 11.24

43. WHO's approved Programme budget 2010–2011 amounts to US\$ 4540 million. As at the end of 2010, available funds¹ distributed for implementation in the biennium were US\$ 3918 million and are composed of carry-forward from the financial period 2008–2009, assessed contributions and voluntary contributions. A total of US\$ 1862 million (41% of the approved budget) was implemented.²

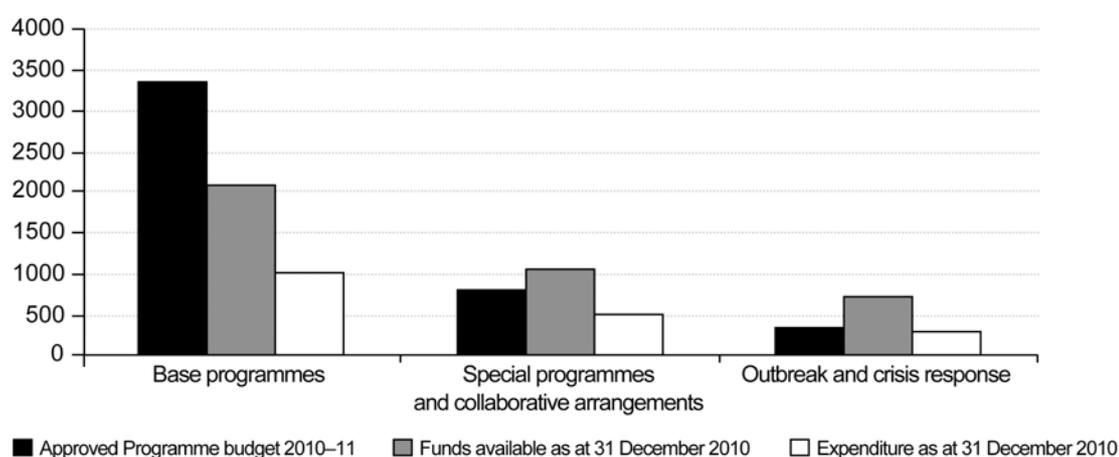
44. Strategic objectives 4, 6, 7 and 9 are currently the least well-funded, but funding for some strategic objectives exceeds the approved Programme budget. In the case of strategic objective 1, for example, the available funding includes in-kind vaccine contributions to the Organization's pandemic (H1N1) 2009 response, as well as funding for the Global Polio Eradication Initiative.

¹ Available funds include US\$ 925 million (24% of the available funds) from assessed contributions (excluding contingency withholdings for non-payment of assessments), US\$ 1377 million (35% of available funds) from carry-forward from the financial period 2008–2009 and the balance comes from voluntary contributions. It differs from operating revenue reported in the unaudited financial report 2010, which reflects only income recorded for 2010.

² Implementation: this figure represents expenditure and does not include US\$ 138 million of commitments (encumbrances) made for goods and services which were not delivered as at 31 December 2010 and are not recognized as expenditure for accounting purposes.

**Table 3. Financial implementation by budget segment
(US\$ million as at 31 December 2010)**

Segment	Approved budget 2010–2011	Funds available as at 31 December 2010			Funds available as % of approved budget	Expenditure as at 31 December 2010	Expenditure as % of approved budget	Expenditure as % of funds available
		Assessed contributions	Voluntary contributions	Total				
Base programmes	3 368	918	1 191	2 109	63	1 035	31	49
Special programmes and collaborative arrangements	822	6	1 066	1 072	130	517	63	48
Outbreak and response crisis response	350	1	737	738	211	309	88	42
Total	4 540	925	2 993	3 918	86	1 862	41	48



WHO 11.25

45. WHO's approved Programme budget 2010–2011 of US\$ 4540 million consists of US\$ 3368 million for base programmes (74% of the approved 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.

46. The funds available¹ amount to: base programmes, US\$ 2109 million (63% of the Programme budget for base programmes); special programmes and collaborative arrangements, US\$ 1072 million (130% of the Programme budget for special programmes and collaborative arrangements); and outbreak and crisis response, and US\$ 738 million (211% of the approved budget for outbreak and crisis response).

47. Although the level of funding for the other two segments has already exceeded the approved budget, the base programme segment is currently facing a funding gap of US\$ 1259 million between the Programme budget and the funds available as at 31 December 2010. The declining income trend during the biennium is increasing the risk of a substantial funding gap by the end of 2011. In addition to meeting the funding requirements for the biennium 2010–2011, there is a need to have a carry-forward to cover the opening balance necessary for operations at the start of the biennium 2012–2013. Current estimations point to a minimum of US\$ 1000 million required to be available as closing carry-forward in 2010–2011 to meet this need.

48. The level of funds for special programmes and collaborative arrangements is higher than the approved budget (130% of the approved Programme budget 2010–2011). The increase in funds available for the original budget is mostly related to work on poliomyelitis eradication. Total expenditure for this segment is US\$ 517 million (63% of the approved budget and 48% of available funding).

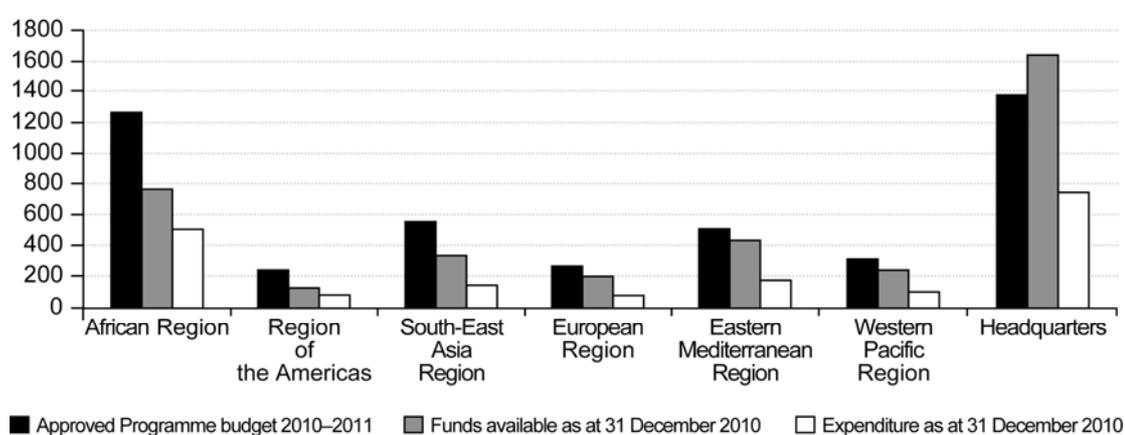
49. The outbreak and crisis response segment also increased, with available resources of US\$ 738 million (211% of the approved budget). The growth in outbreak and crisis response was largely driven by WHO's response to the pandemic (H1N1) 2009 and increasing operational responsibilities in emergencies and humanitarian crises.

50. Expenditure is 31% of the approved Programme budget for base programmes, 63% for special programmes and collaborative arrangements, and 88% for outbreak and crisis response.

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

**Table 4. Financial implementation by major office
(US\$ million as at 31 December 2010)**

Location	Approved budget 2010–2011	Funds available as at 31 December 2010			Funds available as % of approved budget	Expenditure as at 31 December 2010	Expenditure as % of approved budget	Expenditure as % of funds available
		Assessed contributions	Voluntary contributions	Total				
African Region	1 263	205	561	766	61	516	41	67
Region of the Americas	256	79	55	134	52	83	32	62
South-East Asia Region	545	100	245	345	63	139	25	40
European Region	262	61	132	193	74	90	34	47
Eastern Mediterranean Region	515	89	350	439	85	175	34	40
Western Pacific Region	310	77	164	241	78	113	36	47
Headquarters	1 389	314	1 334	1 648	119	747	54	45
Not yet distributed to Major Offices			153	153				
Total	4 540	925	2 993	3 918	86	1 862	41	48



WHO 11.26

51. In most offices, the funds available¹ exceed 50% of the approved programme budget and expenditure is close to 50% of the available resources. The high availability of funds in some major offices, notably the regional offices for the Eastern Mediterranean and Western Pacific and headquarters, is explained by the large proportion of funds for strategic objectives 1 and 5. In both cases, funds were made available for special programmes and collaborative arrangements, for example, poliomyelitis eradication and outbreak and crisis response, including to the floods in Pakistan.

PROGRAMMATIC AND BUDGET ADJUSTMENT MADE ON THE BASIS OF THE MID-TERM REVIEW

52. In view of the current financial insecurity, a task force convened by the Global Policy Group² has identified programme areas, across all levels of the Organization, where the financial shortfalls are the most significant and where activities may have to be scaled down, integrated across programmes or dropped completely. The technical and managerial follow-up actions and appropriate decisions to address risks or impediments that have been identified include:

- identification of priority results to which existing or future funding will be allocated or reprogrammed with the aim of realigning resources and focusing on key activities
- identification of specific plans to achieve efficiencies and cost reductions
- identification of specific results that will not be achieved because of insufficient financial resources and will, therefore, be sunsetted or postponed.

Identification of priority results

53. The programmatic principles defined by the taskforce convened by the Global Policy Group that were considered for priority setting included:

- ensuring that WHO capitalizes on its comparative advantage in the area of communicable disease prevention and control, by focusing on normative work, coordination and provision of focused technical support, monitoring and evaluation, and fostering partnerships. Other partners are better suited to the direct delivery of support to, and implementation in, Member States.
- prioritizing normative and advocacy work on noncommunicable diseases and conditions through the optimal allocation of available funds to strategic objectives 3 (chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment) and 6 (risk factors for health) in order to support critical Organization-wide expected results under the two strategic objectives

¹ Funds available by major office do not include US\$ 153 million of funds which were available for strategic objectives, but not yet distributed to major offices as at 31 December 2010.

² The Global Policy Group is composed of the Director-General, Deputy Director-General and the six regional Directors.

- continue efforts to sustain activities related to Millennium Development Goals 4 (Reduce child mortality) and 5 (Improve maternal health), in particular in areas where the Organization has relative strengths
- giving priority to supporting policy development in the area of health system strengthening by working closely with health ministries and providing guidance and assistance
- reducing WHO's direct involvement in activities on the social determinants of health and environmental health, and, instead, striving to mainstream the relevant functions
- protecting functions related to the International Health Regulations (2005), particularly those where it has been given a clear mandate and Member States' expectations are high, such as capacity building for preparedness and response
- respecting and protecting WHO's humanitarian health cluster coordination functions, given its leading role in the area, and adopting a cross-cutting approach to the critical functions of surveillance and monitoring of health status and trends.

Identification of specific plans to achieve efficiencies and cost reductions

54. Specific plans to achieve efficiencies and cost reductions were established at each level of the Organization by the task force convened by the Global Policy Group and included:

- limiting further growth in staff numbers
- implementing structural changes, including the disestablishment of the headquarters cluster for partnerships, country focus and United Nations reform, the closure of the WHO offices at the World Bank and in Washington DC; merging of departments at headquarters and in regions; and the devolution of several regional centres back to the host government
- rationalizing travel costs: reducing the number of external meetings, and the need to travel generally, by increasing teleconferences and virtual meetings; scheduling back-to-back meetings; and limiting staff travel to necessary trips
- reducing printing charges by limiting publication in hard copy to high-priority publications, and publishing electronically where feasible
- outsourcing work and exercising selectivity in the choice of contractors
- working more closely with partners to make efficient use of combined human resources
- reducing the number of agreements for performance of work by maximizing the expertise of existing staff
- considering increasing the use of WHO collaborating centres in order to deliver results
- establishing clear, unambiguous benchmarks and targets for measuring efficiency at different stages in the biennial implementation cycle.

Identification of specific results to be sunsetted or postponed

55. For each strategic objective, results and activities were identified that will either not be delivered or will be reduced in number by the end of the biennium owing to financial constraints.

ACTION BY THE HEALTH ASSEMBLY

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

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